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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXXVI—NO. 3 MARCH, 1918 WHOLE NO. 424

Original Communications

LOCALIZED AREAS OF ATROPHY OF FAT CELLS IN DERMA AND SUBCUTANEOUS TISSUE*

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CASE REPORT

The patient, a girl, aged 19, was admitted to the Students' Hospital and Dispensary, Oct. 2, 1916. Her complaint was that her "left leg is getting smaller than the other." She had been under the care of a physician who had informed her that she was suffering from muscular atrophy. Having learned of the seriousness of muscular atrophy, she was greatly perturbed over her condition.

The family history was negative. Her parents, two brothers, and two sisters were living and well.

The patient had had scarlet fever at the age of 6; measles at 7; mumps at 7; chickenpox at 9; whooping cough at 11; and a tonsillectomy had been done when she was 17 years old. She stated that as a child she was tired more or less all of the time and did not want to play with the other children, and that she had "never had any color." During her high school period she was inclined to be emotional—depressed at times and at other times hysterical. She remained out of high school for one year on account of headaches. The onset of puberty was uneventful. No menstrual disturbances were noted, except that she had been inclined to be somewhat irregular.

During the past two or three years she lost about 10 pounds. At times she had noted shortness of breath and palpitation. Her appetite has always been good. She had not been conscious of any capricious appetite except an excessive desire for chocolate. She has been troubled with constipation. No hyperacidity or distress after eating

*Received for publication Oct. 13, 1917.

has been noted by her. According to her, all organs of the body have seemed normal.

When I first examined the patient her skin was somewhat yellowish green. Examination of the blood revealed the following characteristics: Red blood cells, 3,808,000; white blood cells, 8,000; hemoglobin (Sahli), 75 per cent. A slight poikilocytosis was noted. No other abnormal blood findings were present. The physical examination revealed no other pathologic conditions except atrophic areas on the left leg, which are described in detail later.

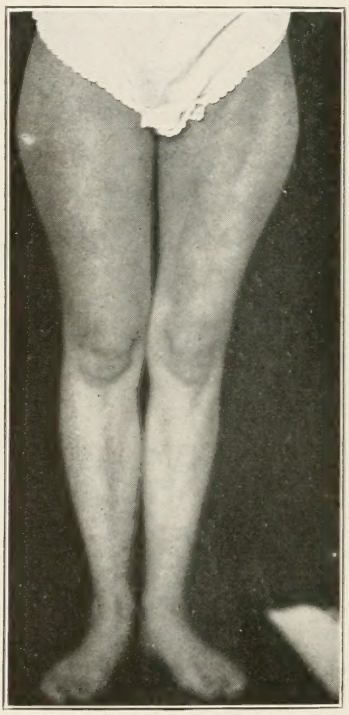

Fig. 1.—Anterior view of extremities. Note the appreciable decrease in the circumference of the left leg at the level of the middle of the thigh and leg.

Notwithstanding the fact that the case had been diagnosed as "muscular atrophy of the left leg," examination showed that all extensors, flexors, rotators, and abductors were as strong and fully developed in the left leg as those in the right leg. The reflexes and cutaneous sensations were normal.

My diagnosis of the case was chlorosis. Although the curious yellowish green tinge was sufficient to suggest this diagnosis the hemoglobin was unusually high for this condition. She stated, how-

ever, that she had been "given medicine for her blood." Doubtless the hemoglobin content had previously been much lower.

Gross Characteristics of the Atrophic Areas.—Two areas of atrophy were present on the left thigh and leg. The larger and more conspicuous one was triangular in shape and occupied about the entire area of Scarpa's triangle. The atrophy here was most pronounced over the rectus femoris muscle (Fig. 1).

Prominent dilated veins, tributaries of the long saphenous (vena saphena magna) were present, and gave to the skin in this area a

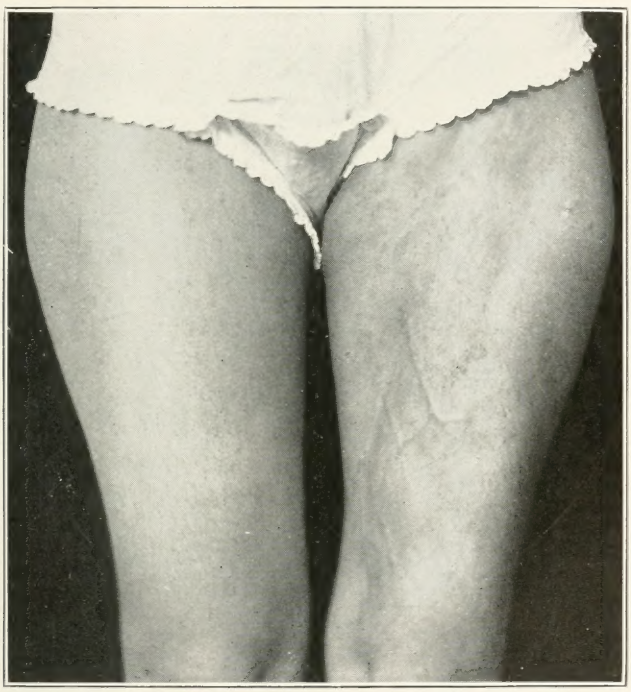

Fig. 2.—In Scarpa's triangle of the left thigh the atrophy is easily seen. Note the prominence of the rectus femoris muscle, the numerous, minute pitlike depressions, and the dilated vein.

bluish tint. On close inspection, minute, slight, pitlike depressions of irregular shapes and sizes were seen (Fig. 2). Otherwise, the skin appeared normal, except for a small, slightly reddish patch more or less circinate in shape and covered with fine scales. This patch suggested ringworm and yielded readily to local treatment for such a condition. On palpation, the skin was soft and elastic. It could be readily pinched between the fingers. On rubbing the fingers over this area, one felt in the subcutaneous tissue strands of connective tissue which were most prominent over the rectus muscle.

The second area of atrophy was found on the anterior surface of the leg beginning 7 cm. below the lower margin of the patella. It measured about 15 cm. long and 10 cm. wide, but had no definite boundary as the margin gradually faded into normal skin. The atrophy in this location was not so pronounced as that in Scarpa's triangle.

No abnormal changes were found in any other part of the leg or thigh. Figure 1 shows that the lateral and median surfaces of the extremities were normal. The posterior aspect was also normal.

Fig. 3.—Photomicrograph. Low power. The sebaceous glands are very prominent in the section due to the complete atrophy of surrounding fat cells.

Measurements taken at the middle of the two atrophic areas showed that there was a decrease in the circumference of the affected left limb. The following measurements were taken:

(1) Left thigh, 24 cm. below anterior superior spine, circumference, 43 cm.; right thigh, same point of measurement, circumference, 48 cm.

(2) Left thigh, 7 cm. above superior margin of patella, circumference, 34 cm.; right thigh, same point of measurement, circumference. 38 cm.

(3) Left leg, 11 cm. below lower margin of patella, circumference, 32 cm.; right leg, same point of measurement, circumference, 34 cm.

From about the center of the atrophic area, a small piece of skin, including the underlying subcutaneous and deep fascia down to the muscle, was removed under local anesthesia. The average thickness of the piece removed was 3 mm. Tissue was not removed from this area from the other leg for comparison, but it was estimated that the thickness of the skin and subjacent tissues due primarily to the fat deposit was at least 1 to 1.5 cm. The difference in thickness between similar areas from the normal leg and the atrophic leg would in all probability be between 0.7 and 1.2 cm.

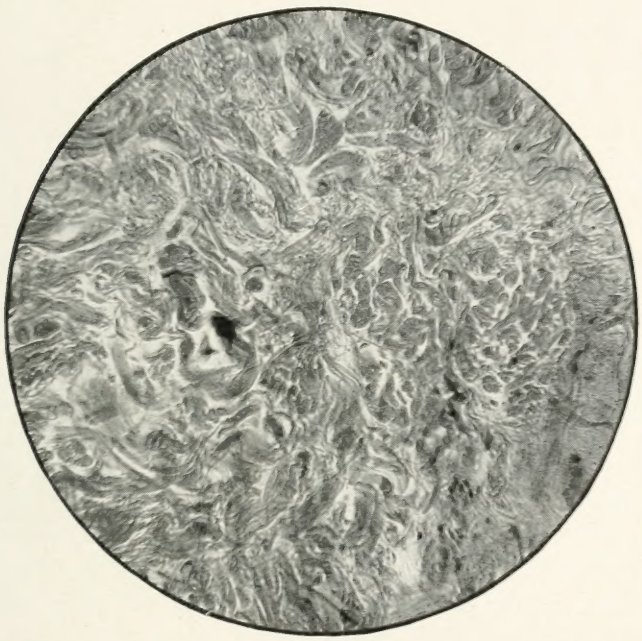

Fig. 4.—Photomicrograph. High power. This was taken from about the center of Scarpa's triangle. Dense sclerotic connective tissue with no nuclear elements.

In the process of dissecting out the area for microscopic study, I noted the complete absence of macroscopically visible adipose tissue.

Microscopic Appearance.—Microscopic examination revealed the following conditions:

The epidermis was normal in structure and staining characteristics, except the corneum, which was more scaly than usual. The various other strata—germinativum, granulosum, lucidum—were normal in appearance. The last two were not in much evidence in this section, and may be regarded as normal.

The cutis was composed almost entirely of dense fibrous connective tissue. No differentiation of the strata papillare and reticulare could be made out. The latter possessed relatively few elastic fibers.

In fact, the entire cutis and subjacent fascia down to the muscle were composed of dense fibrous connective tissue. No fat cells were present. Very few nuclear elements were seen. When present, they were observed only in the cells of the various glands and other ducts, and of the capillary walls. Nuclei were seen only rarely in this dense fibrous tissue and then they were lymphoid in structure. No plasma-cells, mast-cells, clasmatocytes or polymorphonuclear cells were present. There was an appreciable decrease in the subcutaneous blood capillaries and lymph vessels (Fig. 3).

In certain areas the fibrous tissue had a gelatinous appearance. This did not react to mucous stains. The sebaceous and sudoriparous glands had not been affected in this subcutaneous atrophy and were normal both in structure and staining characteristics. They were especially prominent because of the atrophy of the subcutaneous tissue (Fig. 4).

The alterations observed were due to the complete disappearance of fat and an apparent hypertrophy of the fibrous tissue.

No bacteria or other evidences of inflammation were found.

COMMENT

A recent article by Gilchrist and Ketron[1] describes a unique case of atrophy of the fatty subcutaneous tissue. The atrophy was manifested in the form of numerous dimplelike depressions, varying in size from that of a pea to large "sunken, morphea-like patches, which were round, irregular or band-like, and attained to an area the size of 10 by 4 cm. The depth of the atrophy varied from something scarcely perceptible in the smaller areas to about 2 mm. in the larger ones." These pitlike depressions were found only on the lower extremities, extending from the inguinal regions to the ankles. A section from the smallest nodule revealed the following histologic characteristics. The changes affected only the subcutaneous tissue, where a cellular infiltration was seen in the subcutaneous tissue.

"This cellular infiltration, toward its center, had replaced most of the fatty tissue, but toward the periphery of the affected area the fat spaces became more numerous and the infiltrations gradually ended with prolongations or isolated groups of cells which lay between the strands of the fat framework." The cell elements making up this were in the center, cellular connective tissue intermingled with plasma cells, while the periphery of the infiltration consisted of fibroblasts, large endothelioid cells, small round cells, some plasma cells, polymorphonuclear leukocytes, and conspicuous multinuclear giant cells—macro-

1. Gilchrist, T. C., and Ketron, L. W.: A Unique Case of Atrophy of the Fatty Layer of the Skin, etc., Bull. Johns Hopkins Hosp., October, 1916, p. 291.

phages—the cytoplasm of which was abundant, stained faintly and appeared as fine, foamlike structures. These were observed chiefly in the fat spaces, filling them or lining them with glandlike regularity. Sections removed from the larger areas showed in the areas where the atrophy was most pronounced dense sclerotic tissue within which were found nests of fibroblasts, large and small round cells, and plasma cells. At the margin of this larger atrophic area where a transition to normal tissue occurred, were seen the cell infiltrations as described for the small area.

The clinical history of this patient did not reveal the nature of the disease. Slight irregular rises in temperature and high leukocytosis suggested some chronic inflammatory process. Toxic erythema may have had something to do with the case.

Interesting, indeed, is the discussion of the pathologic processes involved. I will quote further from their discussion:

> The histologic findings show that the lesions in their development and evolution follow a definite course, which leads to the ultimate loss of the fatty layer without other permanent changes in the skin. The disease begins with the formation in the fatty layer of small nodules or strands, which are not perceptible to the naked eye, but are recognized only on deep palpation. These small nodules are made up of cells of a chronic inflammatory nature. The inflammatory process spreads only in the fatty layer, the fat itself being taken up in the cytoplasm of large phagocytic cells, which are very striking in appearance. After the fat has been removed the infiltration gives place to a fibrous tissue, the contraction of which leads to the formation of the small atrophic macules visible on the skin and which are bound down to the underlying masses. Later, as the lesions increase in size, this fibrous tissue is itself absorbed, leaving a soft, elastic skin which, owing to the loss of the fatty layer, has sunken down directly on the muscular fascia. Since the edges of some of the lesions showed no induration, the sunken areas rising directly into the normal-feeling skin, the process must be subject to spontaneous arrest. The fact that the areas affected return to a practically normal state, except that the fatty layer is entirely lost, furnishes strong presumptive evidence that the rôle of the pathological process is to remove the fatty layer. This assumption is best supported if we further assume that the fat itself, through some chemical change, has been converted into a substance still of a fatty nature, but which acts as a foreign body in the tissues. The other possibility is to assume that the condition is an infective process, and that the invading organism has a special affinity for the fatty layer, changing the fat into some substance which acts as a foreign body. The difficulty here is that, if bacterial in origin, one would not expect the process to be so narrowly confined to the fatty layer and, also, would not look for such complete restitution of the areas affected after removal of the fat.

The case under my observation differed from that reported by Gilchrist and Ketron in many respects. In the latter numerous atrophic dimples, giving to the legs a distorted contour, were present over the greater portion of the legs. The case described in this paper was unilateral; only Scarpa's triangle and an area over the anterior surface of the tibia were involved. The atrophy was equal and diffuse in these two areas and not characterized by deep, cuplike depressions. Nothing

in the clinical history of this patient indicated a chronic inflammatory condition, as was the case in the one reported by Gilchrist and Ketron.

The chief histologic differences between the two cases is that in the case here reported no cellular infiltrations or macrophages were found. In fact, the section was characterized by the almost complete absence of any nuclear elements. Only sclerotic tissue was present. No evidences of an inflammatory character were observed. While tissue was not removed for study from the margins of these atrophic areas, the history of this case shows that the atrophy occurred simultaneously throughout the areas involved and that no inflammatory process was concerned in the production of it.

DISCUSSION

The dilated superficial vein, particularly in Scarpa's triangle, indicated that there was some obstruction to the venous system of this extremity. Osler,[2] in his discussion of chlorosis, states: "Thrombosis in the veins may occur most commonly in the femoral, but occasionally in the cerebral sinuses. In 86 cases, the veins of the legs were affected in 48, the cerebral sinuses in 29 (Kichtenstern)."

In view of the fact that this patient gives a history of long chlorosis and with the presence of dilated tributaries of the vena saphena magna, one may reasonably conclude that a certain degree of thrombosis may have occurred of either the femoral or long saphenous vein. We may assume that associated with this passive congestion a certain degrec of malnutrition existed, which had manifested itself in the atrophy. The presence of a translucent, gelatin-like tissue in certain areas of the section which normally would be occupied by fat, suggests that something in the nature of a serous atrophy may have occurred which is, according to Flemming, essentially a fat atrophy—the place of the fat being taken by serous fluid which further infiltrates into the surrounding tissue. According to Adami,[3] this type of atrophy is seen in wasting diseases affecting more particularly the epicardial and perirenal fat deposits. That an early disappearance of fat occurs in malnutrition is well known.

One cannot hold, however, that the complete disappearance of subcutaneous fat in these areas can be entirely explained as resulting from circulatory disturbances—passing congestion due to thrombosis. Many atrophies are accompanied by fatty infiltrations. Again, just why the subcutaneous atrophy should be limited to these two areas described cannot be fully explained.

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2. Osler, W.: The Principles and Practice of Medicine, New York, D. Appleton & Co., 1912, p. 73 B.

3. Adami, J. G.: Principles of Pathology, Philadelphia, Lea & Febiger, 1, p. 3905.

This case shows that more or less circumscribed areas of the subcutaneous tissue may undergo complete atrophy of the fatty tissue independent of infectious processes.

Note.—The patient was last seen March 10, 1917, a little more than five months after her first visit. During this time she had followed carefully the instructions given regarding, diet, habits, etc. She had taken the regulation treatment for chlorosis—iron in the form of Blaud's pills. The blood findings were about normal. Her skin had a much more natural appearance. She stated that she had not felt so well for a long time. In addition to the treatment mentioned, she had massaged the atrophic areas daily with animal oils. The atrophic areas had not increased. On the other hand, there appeared to be a less degree of atrophy than when first observed, and there was a slight increase in the circumferences of the leg at the levels of the centers of the two atrophic areas.

A PAINFUL NODULAR GROWTH OF THE EAR*

O. H. FOERSTER, M.D.
MILWAUKEE

Four instances have recently come to my notice of a small nodular, painful growth occurring on the rim of the ear. While at first glance the lesion does not appear to differ essentially from the keratotic growths frequently found on the auricle, even this small group of four cases shows such uniformity of clinical features that further investigation appears desirable.

While I have not observed the lesion at its inception, it is described by the patient as primarily a localized thickening of the skin, "like a tiny flat kernel," developing without the history of preceding injury.

It is painful on pressure from the beginning, and the pain usually first attracts attention to the existence of the lesion. Later the pain may be moderate or quite acute, and prevent resting of the head on the affected side, or it may occur without the incidence of pressure and resemble the darting pain of a corn. In one instance the pain was severe enough to indicate excision of the growth.

In three cases the lesion was situated on the posterior surface of the helix, slightly below the top of the curve of the auricle, and in one case on the margin of the helix.

The growths are single, ovoid, well defined, rose-red nodules, varying from 3 to 4 mm. in their longest diameter, embedded in the skin, but only in one instance firmly attached to the underlying cartilage. The nodule is flat-topped or slightly convex, with a sloping margin, and has a shallow central depression filled in with an adherent scale. The skin surrounding the base is normal in appearance and presents no evidence of seborrheic change.

The growths appear suddenly, without the history of preceding injury to the part, reach their maximum size within a few weeks, and then remain stationary. In one instance the growth had been present without change for ten years, beginning at the age of 21 years. In the other cases observed the lesion had been present for 8, 12 and 18 months, and the patients were 56, 62 and 51 years of age, respectively. All four patients were males.

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* Received for publication June 4, 1917.

* Read before the Forty-First Annual Meeting of the American Dermatological Association, Cincinnati, May 24-26, 1917.

Judging from the length of time that one of these growths existed unchanged (ten years) there appears to be no tendency to malignant change, and the histopathology of the lesion is in conformity with this.

HISTOPATHOLOGY

Microscopic examination of a nodule excised with the adjacent cartilage, shows a diffuse inflammatory and degenerative process of the corium, associated with considerable epithelial hypertrophy.

The stratum corneum is made up of ten to thirty layers of loosely laminated hyperkeratotic scales, which dip into the rete at various places, forming small horny plugs.

The stratum granulosum shows from five to seven layers of well-formed cells.

The rete shows marked acanthosis, particularly at the center of the lesion where the pegs are much lengthened and broadened, and in places confluent. There is no edema or degenerative change of the rete, and the basal layer is everywhere intact. There are isolated aggregations of rete cells in the cutis, which are evidently snared off pegs. There are no evidences of malignant change.

The entire corium shows a generalized edema with dilatation of the lymph spaces, thickening of the blood vessels, and perivascular infiltration. This consists chiefly of round cells and epithelioid cells, with a few scattered plasma cells. The collagen shows a granular degeneration and the elastic tissue is also degenerated, taking the basic stain and showing fragmentation. The cartilage itself shows no change. There are two circumscribed areas of inflammatory reaction lying over the cartilage, consisting largely of round cells, epithelioid cells, and polymorphonuclear leukocytes.

It appears that this nodular lesion differs in both clinical and histologic features from the keratotic growths, and bears only a slight clinical resemblance to epithelioma. Further and more complete histologic study of the material from several cases will be required before a definite conclusion is reached as to the nature of the growth. As far as determined, it is a localized area of chronic inflammation, in some respects resembling lichenification.

Treatment with roentgen rays resulted in the entire disappearance of one lesion, was without result in another, and was followed by recurrence in a third case, after eight weeks. The galvano-cautery, electrolysis, or carbon dioxid snow would appear to be preferable methods as they are actively destructive.

In presenting this brief report, I wish merely to bring to your notice a condition which doubtless is not of rare occurrence, but has thus far

escaped closer study. I have not been able to find in the literature a description of any condition resembling this growth, although it is not infrequent, for a number of dermatologists have informed me that instances of this disorder have occasionally been observed by them.*

* Since this paper was presented, Dr. O. S. Ormsby has kindly called my attention to an article by Dr. Max Winkler (*Arch. f. Dermat. u. Syph.*, April, 1915) entitled "Chondro-Dermatitis Nodularis Chronica Helicis." The condition there described, both clinical and histologic, corresponds closely with the cases observed by me.

RHUS DERMATITIS*

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SENDAI, JAPAN

The plants of the rhus family, which in Japan grow wild, consist of the following six kinds: (1) rhus tricocarpa et rhus tricocarpa var. serrata; (2) rhus semialata var. Osbeckii; (3) rhus toxicodendron var. radicans; (4) rhus sylvestris; (5) rhus vernicifera, and (6) rhus succedanea.

It is well known that especially rhus toxicodendron and rhus vernicifera are the most injurious plants. A large number of cases of severe dermatitis have originated from contact with the plants. The first description of rhus dermatitis can be found in the Orient, namely, in Ping-yuan-hon-lun (605 to 609 A. D.), in China, and later in Wamyo-rui-ju-sho (923 to 930 A. D.), in Japan. This matter was transmitted to Europe at a late date from the Orient, that is, in the eighteenth century, by Kämpler. The clinical features of dermatitis venenata provoked by the plants of the rhus family are generally well known, namely, the symptoms develop in the course of several hours to one week after contact with the poisonous plants, usually on the exposed surfaces of the body (more particularly the face, neck and hands) and on the genitals. They consist of a confluence of papules, vesicles, sometimes even bullae, accompanied by heat, redness, edematous swelling, itching or burning sensations. Itching may become intolerable and it is commonly worse at night or early in the morning. In more severe grades, pustules may rise from an intensely reddened skin, and oozing from the denuded surface may occur. As a rule, a few days later the process reaches its maximum, then, tending to gradual diminution, finally disappears within a few days under slight desquation, without leaving cicatrices behind. The general health remains unaffected even in the severe form. As to the symptoms of lacquer poisoning, we need not go into details, as they closely resemble acute forms of eczema.[1]

It has not as yet been decided what constituent is the poisonous ingredient of the plants. Some authors say it is a volatile substance, whereas others maintain that it is nonvolatile. The former believe that predisposed individuals are affected at a distance by the exhalations from the plants. For example, it is claimed that rhus dermatitis

* Received for publication Sept. 25, 1917.

1. The clinical features of the disease have been minutely described by White in his excellent monograph, "Dermatitis Venenata," 1887.

may attack people who pass under a lacquer tree or sometimes even by passing a lacquer-ware shop front. Hikosaka[2] reports the case of a man who was affected at a distance of several rods from a lacquer tree. New lacquered ware has provoked an acute dermatitis in a large number of patients, whereas an old lacquered article always remains harmless with reference to any eruptive disorders. Maisch isolated his "toxicodendric acid" by distillation of the poison-ivy, and believed that there was also a poisonous volatile substance. Yoshida and Korschelt[3] reported that lacquer contains a volatile poison soluble in alcohol in company with the so-called "urushin acid." The poison disappears, it seems, when the urushin acid dries. On the whole, Scheube[4] and Mense[5] agree with him on this question.

Many others have been absolutely opposed to the above-mentioned views. Pfaff[6] reports that it is a nonvolatile oily substance which he called "toxicodendrol," obtained by distillation from alcoholic extract of the leaves of the plants. Tschirch[7] and Jadassohn maintained that the injurious component of the Japanese lacquer was a nonvolatile substance, the so-called "vernicoferol" Tschirch, capable of solution in petroleum-ether and alcohol. As Tschirch himself stated, the substance was by no means chemically pure. Syme[8] described the harmful ingredient of the poison-ivy as a complex substance of a glycosidal nature, yielding gallic acid, fisetin and rhamnose. The toxic agent was nonvolatile.

Investigators have since been divided in their opinion regarding the harmful component of the plants.

NATURE OF THE INJURIOUS CONSTITUENT

In the first place, as previously stated, a diversity of opinions exists as to whether or not the injurious substance is volatile. A number of people who have markedly susceptible skins for rhus were used in our experiments. As to animals, according to our preliminary experiments, the young cat and the young rabbit have the most susceptible skins of all the domestic animals. Young rabbits were tested by applying rhus poison on the interior surface of their ears. All developed dermatitis, characterized by heat, redness and edematous swelling, frequently by vesicles and bullae, sometimes even ulcers.

2. Hikosaka: Tokio-Iji-Shinshi, 1882.
3. Yoshida and Korschelt: Transaction of the Asiatic Society, 1883.
4. Scheube: Die Krankheiten der warmen Länder, 4 Auflage, 1910.
5. Mense: Handbuch der Tropenkrankheiten, Band 2, 1914.
6. Pfaff: Jour. Exper. Med., 1897, 2. p. 181.
7. Tschirch: Harze und die Harzblätter, 1906. Arch. Pharm., 1905.
8. Syme: Johns Hopkins University Dissertation, 1906.

To determine, if possible, the character of the injurious substance two experiments were undertaken.

(*a*) Steam was led into a lot of Japanese lacquer under various temperatures, in order to drive out all volatile substance. The substance contained in distilled water shows an acid reaction and has a characteristic smell. The substance from the skin of men and rabbits was examined in various ways, and we could demonstrate at least that the volatile substance must be harmless in any case.

The distillate from the alcoholic solution of the lacquer also was harmless. Then the distillate was extracted by ether, petroleum-ether, or chloroform. The remainder, after evaporation of the extractors, was equally harmless.

Then the distillate of the lacquer was put into a box with two young rabbits, for about four hours. The result was negative also.

We placed a large quantity of lacquered iron-plate into a drying apparatus, at 150° to 200° C. The smoke which is produced by combustion of lacquer was indifferent to the susceptible skin. There is a common observation that smoke of burning rhus plants is poisonous. Adelung[9] confirmed the possibility of the popular belief by experimental studies. The smoke from burning rhus leaves, when blown on the skin of a susceptible person, causes dermatitis. A nonvolatile substance may, however, be carried by the particles of soot in smoke, because a recent experiment in this problem was made by McNair,[10] who concluded that the smoke filtered through glass-wool was not poisonous.

(*b*) An involatile part of the lacquer, which remained from distillation, was extraordinarily harmful.

The lacquer subjected to six to eight hours of boiling water, kept its poisonous power to the full extent.

Recently lacquer was found on an antique jar, which was buried in the ground about a thousand years ago, taken from a ruin in Japan. There was Japanese lacquer, quite shrivelled, inside. We proved by the experiment that the petroleum-etheric solution of this lacquer was poisonous, in spite of the fact that it had lost all of the volatile component during the centuries it had been buried.

In view of these facts it is evident that rhus has no volatile poison.

ETIOLOGIC FACTORS

What is the cause of rhus dermatitis? On the one hand, we know that the petroleum-etheric solution of the lacquer is especially harmful,

9. Von Adelung, E.: An Experimental Study of Poison Oak, Arch. Int. Med., February, 1913, p. 148.

10. McNair, J. B.: Jour. Infect. Dis., 1916, 19, p. 419.

and on the other hand, we also know that the principal ingredient of the rhus is "urushiol." Accordingly, the harmful ingredient may probably be identical to the principal substance. Crude urushiol may be obtained from the sap of the lacquer tree, raw-lacquer (Japanese "ki-urushi"), by dissolving in absolute alcohol, and evaporating the alcohol from the filtrate of this solution. The petroleum-etheric solution of the crude urushiol is filtered, and then the petroleum-ether is evaporated from the filtrate. In this way the urushiol may be purified.

Some individuals are affected intensively by the urushiol, especially by the refined product, whereas others are quite immune to the poison. Susceptibility to the poisonous action of the urushiol and the plants of the rhus family is common; that is to say, a patient who suffered from rhus dermatitis must be harmed by the urushiol. The animals susceptible to the lacquer, for instance the cat and the rabbit, are also sensitive to the urushiol. And we can find no point of difference between the urushiol-dermatitis and the lacquer-poisoning with regard to the symptoms and the histologic findings. Indeed, I believe that the poisonous action of the urushiol is more powerful than that of the plants or of the lacquer. If applied to susceptible skins, 1/100 mg. of urushiol dissolved in a drop of olive oil produces, within fourteen hours, a few red papules of pinhead size, accompanied by itching. Twenty-four hours later, a large number of papules, discrete or set closely together, appear at the point where the poison had been applied. They tend to involution after thirty-eight hours, and disappear finally in the course of three days; 1/1000 mg. of urushiol, applied as aforesaid, is also still harmful, and produces a group of fleshy, erythematous papules, accompanied by itching, within twenty-seven hours. These disappeared forty-eight hours later.

According to recent studies by Majima,[11] it is possible that the once refined urushiol can be refined still more by distillation at low pressure (0.2 to 0.5 mm. of mercury). As the urushiol is distillable, a doubt may arise as to whether it is a volatile substance, in a greater or lesser degree. However, if the urushiol is distilled at atmospheric pressure, it is distilled dry. At a temperature above 270° C. it is solidified and decomposed for the most part. In order to distil without decomposition taking place, therefore, it is necessary that it be distilled quickly, at a pressure of at least 0.5 mm. or so of mercury. Even in this was only a part of the urushiol distils at from 210° to 220° C., whereas the greater part decomposes and recombines on being heated. Accordingly, as is the case with glycerin or olive oil, the urushiol is not at all a volatile substance.

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11. Majima: The Journal of the College of Science, Imperial University of Tohoku.

The distilled urushiol causes an acute dermatitis similar to that induced by the plants of the rhus family or by the unrefined urushiol. Indeed it seems to me that the distilled urushiol is the most injurious of all similar preparations, because a man who had no susceptibility to the refined urushiol or the plants of the rhus family, was attacked evidently by the distilled urushiol, even though the eruption did not spread from the skin surface affected by the poison. Furthermore, 1/1500 mg. of the distilled urushiol, dissolved in a drop of olive oil, produced, within about twelve hours, in susceptible skins, an erythema and several dozen follicular red papules, which lasted two days, accompanied by itching. In the dose of 1/1000 mg., it produced a more marked dermatitis of three days' duration.

I wish to state here, that the principal ingredient of the ivy is the same, both in its chemical character and its poisonous action, as that of the lacquer.

Under these circumstances the following conclusions can readily be reached: (*a*) The cause of the rhus dermatitis is found in urushiol, a principal ingredient of the lacquer; (*b*) the harmful component of the rhus is nothing more or less than its principal one.

Dependence of poisonous action on chemical composition

What relation exists between toxicity and chemical construction? "Urushiol," Majima says, "is a sort of polyvalent phenol, especially showing the characters of orthodiphenol; but it is not certainly an acid as many authors considered. And it seems, phenyl radicals are combined with two hydroxyl radicals and one unsaturated alkyl radical, $C_{18}H_{27}$ in bonds. If one distils refined urushiol, previously methylated at low pressure, dimethyl urushiol will be obtained, which has the characteristics of phenol-ether. A crystallized and saturated compound, called hydrourushiol, exists when hydrogen is added to double-bond with an unsaturated alkyl radical of urushiol. In the same way a crystallized product, hydrourushiol-dimethyl-ether, can be obtained by reduction of dimethyl urushiol."

Hydrourushiol dissolved in alcohol or mixed with a certain harmless ointment was applied, as it is almost insoluble in olive oil. In susceptible skins, a dose of 1/100 mg. of hydrourushiol gave rise to no reaction, whereas 1/10 mg. produced a marked dermatitis, namely, a dozen red papules of pinhead size appeared, and an itching sensation developed within forty-eight hours on the areas with which the toxic agent came in contact. The process reached the point of greatest intensity on the following day and subsided seven days later. Of course, application of 1 mg. produced dermatitis within six hours; the inflam-

mation advanced gradually and finally showed symptoms similar to those of lacquer poisoning.

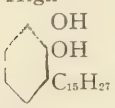
Urushiol-dimethyl-ether and urushiol-monomethyl-ether also show their poisonous action in subjects susceptible to rhus. While 1/10 mg. dissolved in a drop of olive oil was harmless, 1 mg. applied undiluted produced dermatitis. Development of an itching sensation occurred after four hours. A coffee-bean sized urticaria, surrounded by a large number of red papules, would appear within six hours. The inflammation, however, on the whole, was less than that produced by hydro-urushiol.

Hydrourushiol-dimethyl-ether showed no poisonous action, even in individuals susceptible to rhus.

In view of the result just described, we must recognize the fact which we cannot overlook, namely, that a particular relation exists between the chemical construction of urushiol and its poisonous action on the skin. With regard to the construction of urushiol, Formula A is considered correct. Its poisonous action is, therefore, entirely due to the existence of two hydroxyl radicals and adjoining unsaturated alkyl radicals. Especially the influence of the former must be greater than that of the latter, for the intensity of the poisonous action of urushiol and its derivatives is in the following order.

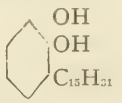
Toxicity

High



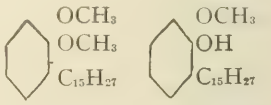
A. Urushiol.

Intermediate



B. Hydrourushiol.

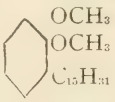
Low



C. Urushiol-dimethyl-ether and urushiol-monomethyl-ether.

Hydrourushiol-dimethyl-ether (D) is harmless, because it has neither free hydroxyl radical nor unsaturated alkyl radical.

Harmless



$C_{15}H_{31}$ saturated alkyl radical.

D. Hydro-urushiol-dimethyl-ether.

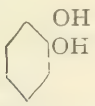
I believe such an orderly relation must be a positive proof that the cause of rhus dermatitis is urushiol.

I tried, furthermore, to discover what influence the position and magnitude of the alkyl radical have on toxicity. Pyrocatechol (E), hydroquinon (F), and resorcinol (G), caused a blackish discoloration of the skins of man and animals by external application, but they were commonly harmless.

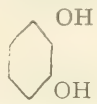
Homopyrocatechol (H) and isohomopyrocatechol (I) had almost the same action; their toxicity was low and they produced a slight dermatitis, which disappeared in a short time. Dioxypropyl-benzene J and K produced sometimes severe, sometimes slight, inflammation of the skin; their toxicity was lower than that of urushiol or hydrourushiol, but higher than that of homopyrocatechol and isohomopyrocatechol. The poisonous action of isohydrourushiol (L) and hydrourushiol (M) was of the same quality and same extent. In a word, the compounds with greater alkyl radical are more harmful, but the position of the alkyl radical is almost wholly unrelated to the toxicity.

As a matter of course, urushiol, which has a great and, moreover, unsaturated alkyl radical in side-bond, must be most injurious.

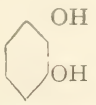
Harmless



E. Pyrocatechol.



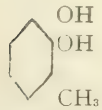
F. Hydroquinon.



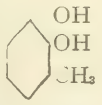
G. Resorcinol.

The following preparations caused more or less dermatitis by external use.

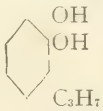
Harmful



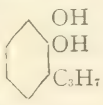
H. Homopyrocatechol.

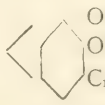


I. Isohomopyrocatechol.

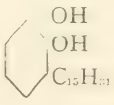


J. K. Dioxypropylbenzene.





L. Isohydrourushiol.



M. Hydrourushiol.

PATHOLOGY OF RHUS DERMATITIS

How shall we explain the so-called infection at a distance, *if we assume urushiol as the cause of rhus dermatitis?*

In the cases in which dermatitis is induced by passage under a lacquer tree, it is to be explained as follows: A small quantity of sap, dropping from an injured part of the plant, can reach a person through the agency of the wind. Or, it is possible that insects carry poison from plant to person, as Hubbard[12] considered probable. As even 1/1500 mg. of urushiol can produce inflammation in a susceptible skin, minute particles of lacquer are quite enough to induce lacquer poisoning, if they are conveyed directly or, by mediation of the insect, indirectly to a susceptible subject. Schwalbe[13] considered that the poison contained in the pollen or trichoms that have fallen from the tree and are scattered by the wind, may be conveyed to susceptible individuals.

12. Hubbard: Med. Brief, 1904, 32.
13. Schwalbe: Med. Record, New York, 1903; München, med. Wchnschr., 1902.

But this theory is doubtful, because Inui,[14] Warren,[15] Rost and Gilg,[16] and McNair[10] have found that the plant's hair as well as the pollen are nontoxic. The cases in which the disease has appeared after passing a lacquer-ware shop front are due to the mechanical transportation of the poison, as happens during work when dust with the resinous sap is carried by air current. New lacquered ware is harmful, because it can isolate the poison if dryness of the lacquer is still insufficient. The isolation is more easy when the lacquer ware is heated. The reason that contact with old lacquered ware is harmless depends on the decomposition and recombining of urushiol as the years pass. Persons may be poisoned by indirect contact with lacquer on clothing or tools. The poisonous ingredient is made so adherent by resin that it is very hard to wash it from the skin surface affected by the poison, and it spreads much more readily to the places previously unaffected.

HISTOPATHOLOGY

The histologic changes of the earliest process were studied. In the corium the vessels of the papillary layer show dilatation and perivascular cell infiltration, consisting chiefly of round cells. Especially marked are the changes associated with the sweat ducts in the papillary layer. There is an edematous infiltration which is quite extensive, forming papules and elevated areas. At times it occurs only about the hair follicles, producing perifollicular papules. There is a parenchymatous edema of the epithelial cells, and this is most extensive in the neighborhood of the sweat-pores and hair-follicles. Here swelling, vacuolization, granulation and even necrosis of the epithelial cells is seen.

According to the histologic findings, the pathogenesis of the affection may be thus interpreted: Minute particles of urushiol reach the skin surface and they oxidize easily by the agency of "laccase, Bertrand," which is contained in lacquer itself, or by other oxidases in the skin. It seems that in the process of oxidation there ensues a poisonous action. The pathologic changes commonly begin about the sweat-pores or hair-follicles, because these orifices offer ready ingress to the poison. Retention of lacquer or urushiol, even in minute particles, and its subsequent oxidation, causes changes both in the epidermis and in the corium, which may be limited to the common excretory duct and the hair-follicles, but which involve usually the tissues surrounding these structures.

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14. Inui: Botan. Centralbl., 1900, 3.
15. Warren: Am. Jour. Pharm., 1913, 85.
16. Gilg: Ber. d. deutsch. pharm. Gesellsch., Berl., 1912, 22, p. 296.

Treatment

One of the most common errors in therapy lies in the frequency with which a succession of many medicaments is tried, instead of studying more carefully the cause of the affection. There is harm in the application of various kinds of plasters, pastes, ointments, and similar preparations without possessing the least advantage, because the substance having the injurious effect, even in minute particles, is spread out in this way on neighboring sound skin surfaces, without being neuralized beforehand. We believe that the purpose of treatment and prophylaxis should be directed only towards the neutralization or destruction of the urushiol, the injurious ingredient of lacquer. For this purpose an alkali, nitric acid, and sugar of lead should be applied. If a history of contact with the plants of the rhum family be obtained, I recommend at first the application of an alkali, as many authors have done. A solution of sodium carbonate or potassium carbonate in water and aqueous ammonia have been employed to advantage; alkaline baths also do well. One of the most effective and trustworthy remedies was the following solution:

	gm. or c.c.
Caustic potash (potassium hydrate)	1.0
Alcohol	30.0
Glycerin	10.0
Water	60.0

The suspected skin surfaces should be rubbed off, with cotton moistened in this solution. These methods are not only necessary to neutralize the urushiol, but they have another advantage, namely, they reveal the skin surfaces affected by the poison. The lacquer adhering to the skin appears, by the action of the alkali, as spots or lines of blackish color, if its quantity is not too little. The spots and lines can be removed by the application of an alcoholic solution of 1 per cent. of nitric acid. The skin may now be washed with water and soap. I found useful the solution of plumbum aceticum in alcohol or water (1 or 2 per cent.) employed as a cold wet compress after the onset of the inflammatory process.

References

This report is an abstract from our Japanese works. For full details consult:

1. Toyama and Kayaba: Tokio-igakkai-zasshi (Mitteil. d. med. Gesellschaft zu Tokio) and Hifuka-Hitsunyokika zasshi (Japan. Ztschr. f. Dermat. u. Urol.), 1915.

2. Majima and Toyama: Tokio-kagakkai-zasshi (Mitteil. d. chem. Gesellsch. zu Tokio), 1915.

3. Toyama and Kayaba: Hifuka-Hiksunyokika-zasshi (Jap. Ztschr. f. Dermat. u. Urol), 1916.

SCHAMBERG'S PROGRESSIVE PIGMENTARY DERMATOSIS

REPORT OF A CASE WITH HISTOLOGIC STUDY

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In a rather careful search of the literature one is impressed by the infrequency with which Schamberg's disease has been observed. American literature contains a record of the first case only, that reported by Schamberg in 1901. At various times since that year, cases have been observed in England, and the results of these studies are to be found in the English journals. The condition has apparently received little or no attention from French and German physicians, as a review of their literature reveals nothing related to this dermatosis. These facts, together with the very evident lack of detailed data make it seem probable that the report of another case in this country with perhaps additional findings may be of some interest.

Case Report

History.—The case which forms the material for this study occurred in a native of this state, Mr. J. W. S., who entered the dermatological service of the University Hospital in May, 1917. The man was 66 years of age and apparently in good health. He was a farmer by occupation. The family history was entirely negative. The patient gave a history of repeated attacks of "rag weed poisoning" which have recurred yearly for the past twenty years. He had malaria when a young man and was operated on for gallstones three years ago.

The present condition started in 1912, at which time he noticed a "brown spot" on the outer aspect of the left leg. This gradually grew larger by peripheral extension for one and a half years, when it slowly began to fade. At that time the patient was operated on for gallstones, and following the operation the condition again became active, and has been gradually enlarging up to the time of examination. About one year ago similar changes made their appearance on the opposite extremity and as with the former, have gradually enlarged by peripheral extension. Throughout the course of the disease there have been no marked subjective symptoms.

Examination.—This reveals a rather tall, well-built, fairly nourished, elderly man. The face and hands are tanned from exposure. There is a slight irregularity of the right pupil, but both react to light and in accommodation. The integument of the upper extremities and trunk presents nothing noteworthy. Involving the middle third and upper half of the lower third of the antero-internal aspect of the left leg, there is an irregularly rectangular patch of pigmentation measuring roughly 7 to 9 inches in length and 3 to 5 inches in breadth (Fig. 1). The involvement in the lower half of the patch is complete and gives one the impression of a reddish brown, or rusty, discoloration.

* Received for publication, Nov. 16, 1917.

The upper half is similar, but is interrupted in places by irregular plaques of nonpigmented skin. The borders are rather well defined and are characterized by outstanding pinpoint, to pinhead sized macules of a slightly lighter tint so well described by Schamberg as "punctate, cayenne-pepper like lesions." There is a similar solid patch of pigment just below the left internal malleolus. The right limb is involved to a lesser extent, the process being confined to the anterior aspect and consisting of closely set, brownish-yellow cayenne-

Fig. 1.—Schamberg's progressive pigmentary dermatosis in a man, aged 66. Note the intense pigmentation of the lower third of the left leg, above which are seen the typical punctate, cayenne-pepper like macules. The macules are less distinctive on the right leg.

pepper like macules. These have in places become confluent giving rise to solid patches of a darker hue. The picture in each case suggests a primary collection of small macules which as they become more numerous, coalesce to form larger patches. The latter apparently enlarge peripherally by confluence

of the smaller lesions along the advancing border. There is some scaling over certain of the patches and the integument generally exhibits a certain degree of senile atrophic change. The process shows an entire absence of any papular element and there is no evidence of any subjective symptoms. There are no varicosities, nor are there any signs of circulatory stasis. The Wassermann reaction is negative.

MICROSCOPIC STUDY

For further study, two specimens were obtained at biopsy. One included a single pinhead sized macule from the advancing border, the other being taken from the central part of the older, more deeply pigmented portion. The tissue was hardened in successive strengths of alcohol, embedded in paraffin and the sections stained after the several methods described in the following pages.

Sections taken from the older portion of the lesion and stained in hematoxylin and eosin were first studied and presented the following changes (Fig. 2):

In the stratum corneum there was a certain degree of parakeratosis, but nowhere was this a marked feature. The stratum granulosum and stratum lucidum appeared practically normal. The rete Malpighii presented an atrophic appearance and not only was there an absence of the rete pegs, but also a decided decrease in the tiers of cells making up this layer. There were to be found occasional migratory polynuclear leukocytes in the malpighian layer and these, as is usual in this location, appeared compressed and elongated. The most striking changes were to be found in the pars papillaris and subpapillary layers of the corium. Aside from an absence of the papillae, a not unusual condition accompanying atrophic changes in the prickle cell layer, there was a pronounced infiltration of the subpapillary portion. The infiltration was generalized throughout the section, but in the upper layers of the corium tended to be circumscribed in places. These circumscribed infiltrates occurred irregularly distributed and in many places surrounded sweat ducts. By the use of Unna's polychrome methylene blue and the Pappenheim stains, the infiltration was later found to be made up of mononuclear lymphocytes, numerous polynuclears, and occasional mast, plasma and epithelioid cells. Throughout the section, but more especially in the subpapillary layer and in the neighborhood of the sweat coils, were irregularly distributed small groups of greenish to golden-yellow granules. These occurred both intracellularly and extracellularly. Stained in orcein, the sections revealed a proliferative endarteritis of moderate degree and numerous newly formed capillaries, the latter occurring especially in the circumscribed infiltrates. The elastica and collagen elements of the sections were practically normal.

The picture just described is that as observed in the older portion of the lesion.* Sections taken from the border differed in two respects: (1) in degree, as the infiltrations were not so numerous or extensive, the endarteritis not so pronounced and the capillary proliferation not so marked, and (2) no pigment granules were visible.

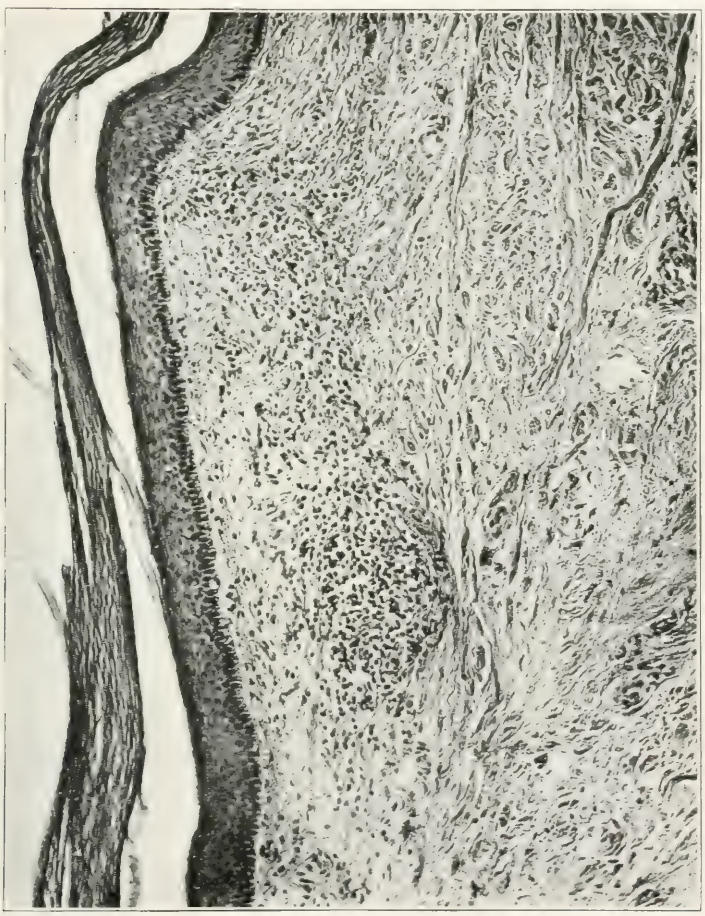

Fig. 2.—Photomicrograph of a section of a macule showing the entire absence of papillae and the dense granular infiltration of the subpapillary layer.

COMMENT

So far as can be judged from previous reports, the clinical aspects of this dermatosis have received most attention. So much so, in fact, that in the two or three cases studied histologically, mention has been

*For corroboration of the histologic findings, and for the preparation of the photomicrographs, I am indebted to the kindness of Prof. A. S. Warthin of the Department of Pathology.

made of the pigment granules in one instance only, and then as a passing consideration in the general histologic description. It seemed from a study of this case that the pigmentary changes in the cutis were of more than passing interest, and with the idea of more definitely

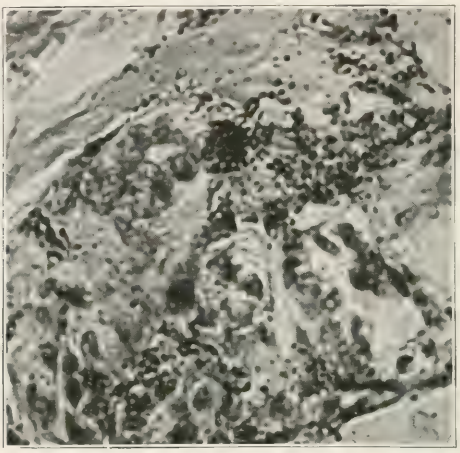

Fig. 3.—Showing the beginning disintegration of the hemoglobin, the marked infiltration and the tendency toward pigmentary granule formation. Specimen taken from the advancing border.

determining their nature, sections were placed in a saturated aqueous solution of potassium ferrocyanid for several hours, differentiated in acid alcohol and counterstained in alum and lithium carmin (Figs. 3

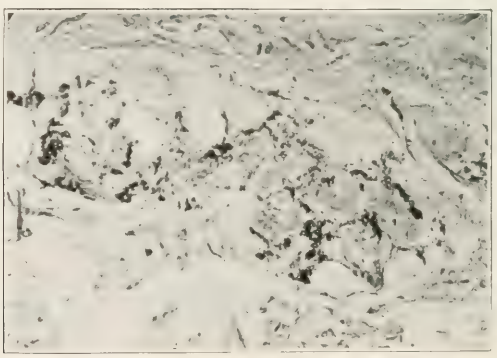

Fig. 4.—Illustrating the dense, intracellular pigmentary deposition characteristic of a chronic, low grade, inflammatory process. Specimen taken from the older, more deeply pigmented area.

and 4). The disseminated granules which were observed gave a most positive Berlin blue reaction, while in the earlier sections in which no pigment was visible with the ordinary stains, the result was equally convincing and differed only in that the granules occurred less fre-

quently and were almost entirely intracellular. In brief, then, one has the picture of a chronic, low grade, inflammatory process, plus pigmentary deposits. The early inflammatory changes and beginning disintegration of hemoglobin observed in the sections from the more recent lesions differs only in degree from the picture of chronic inflammation and pigmentary deposition present in the older process. The pigment being responsible for the clinical picture, it follows that one's interest is directed to the possible explanation of its presence.

Schamberg,[1] who reported the first case in 1901, went only so far as to suggest its analogy, rather than any definite relation to the angioma serpiginosum of Hutchinson. In Freeman's case,[2] reported in 1902, chronic eczema was suggested as a possible explanation. Fox[3] and Little,[4] reporting the next two consecutive cases in 1905 and 1914, took up no etiologic factors in their discussion. Whitfield,[5] who also reported a case in 1914, was of the opinion that the process in his case, and in the case of angioma serpiginosum were "varieties of the same thing." In Adamson's[6] case, reported in 1916, an angiosclerotic condition was suggested as a possible explanation.

In the present case, the entire absence of any papular element, the habit of spontaneous disappearance, and the histologic findings, all rather disfavor the view of angioma serpiginosum being an allied condition. With the chemical nature of the pigment definitely established as an iron derivative, the blood stream as a source naturally suggests itself. The explanation of the comparative absence of pigment in the early sections is obvious when one considers the retrogressive changes through which hemoglobin must pass before hemosiderin is obtained. With the blood stream as the hypothetic source of the pigment, one might conceive of such a condition resulting from a slow but continuous diapedesis through walls of vessels sclerosed to the extent of slowing up the circulation. Yet, the fact that the condition occurs in the young as well as in those of advanced years, would rather discredit this view. The circumscribed capillary proliferation suggests a local angiectatic process through which the circulation is impeded, this in turn giving rise to a diapedesis of red cells, followed by their disintegration in the surrounding tissue, and resulting in a pigmentation limited by the extent to which the capillary proliferation progresses. What etiologic factor activates this localized capillary change is not clear from the clinical or pathologic study of the case at hand.

1. Schamberg: Brit. Jour. Dermat., 1901, 13, p. 1.
2. Freeman: Brit. Jour. Dermat., 1902, 14, p. 425.
3. Fox, Colcott: Brit. Jour. Dermat., 1905, 17, p. 416.
4. Little, Graham: Brit. Jour. Dermat., 1914, 26, p. 334.
5. Whitfield: Brit. Jour. Dermat., 1914, 26, p. 357.
6. Adamson: Brit. Jour. Dermat., 1916, 28, p. 334.

Suffice at present to say then, that we have in Schamberg's progressive pigmentary dermatosis a comparatively rare hemosideric disease — one which occurs in any decade of life, thus far observed only in males and affecting the extremities alone, and appearing both on the continent and in the people of the states; a condition that is apparently secondary to a localized disturbance of circulation, and giving rise to a definite clinical entity.

INFECTION IN CUTANEOUS DISORDERS

A PRELIMINARY REPORT *

HUGH MACKAY, M.D.
WINNIPEG, MAN.

In the domain of dermatology, in the search for the causes of disease, one does not travel far before reaching the realm of the unexplored, the unmapped and uncharted regions where line or plummet has not taken the soundings.

The cases which I am to present before this society tonight, it seems to me, suggest that our views in regard to the etiology of diseased processes in the integumentary structures are about to undergo radical changes; that the time is due and overdue when these views must be brought into alignment with recent advances in medicine, that many of the problems hitherto considered settled in their etiologic aspects must be reopened for further consideration, and a place—sometimes a prominent and exclusive place—accorded to infection as a causative agency in the production of the morbid phenomena observable in diseased conditions of the skin.

Tradition dies hard in medicine. We are wedded to the past, its teachings and its usages. In presenting conceptions more or less variant with those usually recognized in the medical literature of the day, the question to decide is not are they opposed to theories promulgated by this authority or that, but are they in harmony with the clinical findings—that is the acid test, the final court of adjudication.

Since my appointment to the dermatological staff of the Winnipeg General Hospital, I have studied the available clinical material there from this viewpoint, that is, infection, special attention being paid to the teeth and to the tonsils as possible avenues where micro-organisms might gain entrance and carry on their harmful work. In the case of the teeth, I wish to acknowledge my indebtedness to Dr. Lyon Bercovitch of the dental clinic, without whose coöperation and sympathetic attitude these investigations would have been impossible. The incidence of mouth infection in skin affections was found to be unusually large. In some instances the roentgen ray located alveolar abscesses and rarefied areas where such conditions could not be demonstrated clinically, and were quite unsuspected by the patients themselves. Roots left under plates and bridge work were occasionally found.

In many of the acute cases the relationship seemed easy to establish, and the removal of the focus was followed by prompt improvement in

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* Read before the Winnipeg Medical Society, May 17, 1917.

the symptoms. I am not basing my findings, however, on these, because it may be pointed out with force and logic that the ordinary course in skin diseases is to spontaneous cure. At nature's rallying call, the protective agencies of the body are able to hold in abeyance, temporarily at any rate, the influences, microbic or otherwise, that make for disease. But these occult forces, marvelous and potent though they be, are oftentimes unequal to the task imposed on them. Recurrences of the malady take place, and the resisting power of the skin is permanently impaired. Nature having pressed into the service her last recruit, victory rests with the invaders and a condition of chronicity dominates the clinical picture.

With these patients the matter of results in treatment so far as coincidence is concerned, approaches the vanishing point. All the patients presented tonight are cases of years standing. With one exception, the older methods of treatment have been tried and have broken down. Whether the new method of attack is any better—whether its application promises anything for the relief of these sufferers who have all too long been the opprobrium and the discredit of medicine, is for you gentlemen to decide; you are the judge and the jury.

REPORT OF CASES

CASE 1.—Mrs. K., aged 34, came under my care five years ago for urticaria. She has gradually grown worse, the case drifting into the angioneurotic edema class. The swellings were large, recurring frequently on different parts of the body. Some lesions were always in evidence, causing much mental and physical suffering. The teeth were overhauled without the patient deriving any relief. During the time she has been under observation several attacks of tonsillitis supervened. Resolution apparently took place, the tonsils not manifesting any deviation from health. It occurred to me that the removal of the tonsils might be of service. The patient was told frankly that it was more or less of an experiment, but she submitted to having the operation performed by Dr. George Fletcher. Later an examination of these structures was made by Dr. Pierce, who reported "increased connective tissue, many active germ centers." An autogenous streptococcic vaccine was prepared and administered in small doses, guardedly, at weekly intervals. Improvement was rapid, and she is now entirely free from symptoms. Certain foodstuffs which experience had taught her exercised a sinister influence in precipitating seizures, have been rigidly excluded from the diet for years. Now she is under no dietetic restrictions whatsoever. I believe this a case of focal infection from the tonsil.

CASE 2.—J. P., aged 18, came under my care Feb. 27, 1917. The condition was one of chronic urticaria. The trouble developed seven years ago. This lad's teeth were badly decayed. These were removed under an anesthetic by Dr. Wood of this city. No vaccines were employed, and no constitutional treatment or dietetic restrictions instituted. There has been much relief from the subjective symptoms, but the irritable condition of the vasomotor system is still in evidence. Wheals can easily be elicited by external irritation. Dermographism is well marked.

The removal of the focus has not been sufficient in itself to completely overcome the malady. My belief is that his immunity might have been built up by an autogenous vaccine. Possibly there is another focus of absorption which I have not been able to locate.

Case 3.—S. G., aged 12, came under my observation Dec. 30, 1914. This was a case of psoriasis disseminatus in which the scalp was especially bad. Temporary improvement took place following the institution of recognized therapeutic measures. Relapse invariably followed a discontinuance of the treatment. Examination of the teeth by the roentgen ray revealed multiple alveolar abscesses. These foci were cleared up and an autogenous vaccine administered. A symptomatic cure has been effected under this treatment. This method was first applied in my practice a year ago in a case of chronic psoriasis of very advanced grade, and with a like result. To date there has been no recurrence of the disorder.

Case 4.—The patient, M. W., aged 12, had a generalized seborrheic dermatitis of five years' duration; autogenous vaccine was used with marked relief of the symptoms. This patient, like the other, had multiple alveolar abscesses.

My thanks are due Dr. Pierce and Dr. Boyd for laboratory assistance and advice in these studies.

CONCLUSIONS

1. In a preponderating number of cases of inflammatory affections of the skin, diligent search will reveal a focus of infection that may reasonably be assumed to stand in etiologic relationship to the disease.

2. That the vaccines, while far from being cure-alls, are of distinct service in combating these maladies in selected cases.

3. That the removal of the focus, together with the exhibition of an autogenous vaccine, has almost invariably given a measure of relief to these sufferers, and in many cases have brought about a symptomatic cure.

4. That relapses will usually supervene unless the focus is eradicated.

Society Transactions

NEW YORK DERMATOLOGICAL SOCIETY

Regular Meeting, May 28, 1917

JAMES C. JOHNSTON, M.D., *President*

CASE FOR DIAGNOSIS. Presented by DR. LANE.

The patient, J. H., aged 43, was a Jewish tailor, born in Russia. He had had erysipelas when 13 years of age, and a sore on the penis at 21, the latter lesion being diagnosed as not a chancre. He was married in 1902. His wife had had no miscarriages; she had had four children, aged 14, 22, 10 and 8 years, respectively; all the children were healthy. The trouble for which he was presented began six years ago with scaling of the hands, which gradually spread until four years ago the whole body was slightly scaly. The condition had been treated as eczema one year ago, with no change; then treated by another physician for six months, with slight improvement. He had had no treatment from early in 1914, until July, 1915, when the disease was diagnosed as syphilis; about that time he received one intravenous injection (probably salvarsan) and two intragluteal injections of mercury. These were followed by a great increase of redness and desquamation.

May 14, 1917, the entire body was red and desquamating; the palms and soles were thickened; there was alopecia of the scalp and outer half of the eyebrows; the nails were not affected; polyadenitis was present. Several cutaneo-subcutaneous nodules showed a tendency to break down. The Wassermann test was negative and the urine normal. Examination of the blood revealed, white blood cells, 6,500, and red blood cells, 4,500,000. A blood count made two days later revealed the following: erythrocytes, 4,500,000; leukocytes, 6,500; differential (500 cells counted); polymorphonuclears, 370; small lymphocytes, 61; large lymphocytes, 32; eosinophils, 32; myelocytes, 4; basophils, 1.

DISCUSSION

DR. WINFIELD said he had no idea what the condition was. He had seen a number of such cases, and had never been able to decide between pityriasis rubra pilaris and true lichen ruber acuminatus.

DR. HEIMANN said that he, too, had thought of the two conditions mentioned by Dr. Winfield, and also of the leukemic group, including mycosis fungoides. He was inclined to think the diagnosis lay between mycosis fungoides and pityriasis rubra pilaris.

DR. TRIMBLE said that at first glance the case more nearly resembled mycosis fungoides than anything else, although it was not typical. He did not think it was pityriasis rubra pilaris, for the lesion was very dark colored and generalized and there was no great amount of scaling. He was inclined to the belief that it belonged to the group of eruptions that were at times associated with leukemia or pseudoleukemia.

DR. WHITEHOUSE said that judging from the only two cases he had seen, the condition was not the pityriasis rubra of Hebra. Both these cases were much more serious conditions than this, and both patients died. There was no thickening or infiltration of the skin; there was marked exfoliation, leaving a moist, red, shiny surface, and going on to very serious internal troubles of various kinds; the pityriasis rubra of Hebra was a universal exfoliative derma-

titis. From the fact that there were beginning circumscribed areas of infiltration to be seen, it would seem that this was a case of mycosis fungoides.

DR. WILLIAMS said that the case very strongly suggested mycosis fungoides, but he did not care to make a positive diagnosis.

DR. LANE said that he was very glad to have these various opinions, that this case did not seem to be a pityriasis rubra pilaris, for he had never seen the skin break down in that condition as it did in this instance. He had tentatively made a diagnosis between pityriasis rubra of Hebra and mycosis fungoides, but was willing to drop the former after the opinions just expressed. He further said that he would endeavor to make a complete study of the case before the following Tuesday and show the patient again at the clinic of the American Medical Association that afternoon, with everything excepting the biopsy.

CASE FOR DIAGNOSIS. Presented by DR. WHITEHOUSE.

The patient was a barber, aged 28. The eruption began ten months ago in one axilla and gradually spread over the trunk, legs and arms, including the palms. The lesions consisted of small vesicles, later becoming pustules, none much larger than a pinhead and surrounded by a narrow erythematous ring. They appeared in crops like herpetic outbreaks, but were not accompanied by itching nor subjective symptoms, excepting perhaps a slight burning or soreness. On clearing up, they left well-marked pigmentation and, in places, a few tiny scars. Both palms were thickly set with lesions, some active and others dried into small scabs. The patient stated that pressure by a tight trouser-band would often produce an outbreak. He seemed to be a well-nourished man. He had a general adenopathy, including the epitrochlear glands on both sides. He had had measles at the age of 19. His father had died at 41 of a lingering illness of 'six years' duration, beginning as stomach trouble and ending in tuberculosis. The patient was born six days after the father died. Three brothers and sisters were living and well. The patient had a healthy child 3 months old.

DISCUSSION

DR. WINFIELD thought that in spite of the absence of itching the case belonged to the dermatitis herpetiformis group.

DR. HEIMANN agreed with Dr. Winfield.

DR. TRIMBLE said that he had seen the patient before, and had presented him before the Society some six or eight months previously. He did not know what the condition was then, nor did he know now. At that time, however, there were small vesicles all of the same size. These lesions occupied the location where the pigmented lesions were now to be seen. There were then no lesions on the palms and there was no itching. The condition then had existed for two months and the case was presented for diagnosis. After the condition had been treated for a short time, all the vesicles ruptured and formed superficial yellowish crusts, with newly formed vesicles scattered through them. At the time he had suggested a diagnosis of mild generalized impetigo.

DR. JOHNSTON said he had never seen an impetigo that left a pigmentation. The case seemed to him to point rather definitely to an internal origin rather than an external one. There might be a superadded pompholyx.

DR. WHITEHOUSE said that it was probably an impetigo. He had never seen a dermatitis herpetiformis that did not itch. He wondered if the tuberculous history had anything to do with the susceptibility of the skin to a streptococcus or staphylococcus infection. The man was receiving tuberculin.

GRANULOSIS RUBRA NASI. Presented by DR. WINFIELD.

The patient was a young man, aged 19. The condition began when he was 11 years old. The cartilaginous parts of the nose were slightly red, the color

deepening as time went on. At times, there were dark red papules scattered over the diseased areas. There were a few telangiectases present. The nose was cold to the touch and was constantly covered with a sticky fluid. At times, the condition improved, but treatment of various kinds had no lasting effect, except, perhaps, that with the roentgen ray.

DISCUSSION

DR. WINFIELD expressed his gratification that all agreed with the diagnosis, and said that he would like very much to know what to do in the way of treatment. The condition was extending, and the only benefit that had been obtained was from roentgen-ray treatment. He had wondered whether radium would do it any good.

DR. JOHNSTON said that the condition was due to an internal cause and might be overcome by diet.

DR. WINFIELD replied that all sorts of diet had been ordered without any benefit. Roentgen-ray treatment or the high frequency current would clear up the patch for two or three weeks, and then some indiscretion of eating, etc., would bring it back.

CASE FOR DIAGNOSIS (CHLOASMA ?). Presented by DR. POTTER.

The patient was a single woman, aged 50, born in the Dutch West Indies, who had been in the United States for the past nine years. She was perfectly well until three years ago, when a hysterectomy was performed. Since the operation, the patient had suffered from the nervous symptoms, sometimes accompanying the menopause. Examination showed physical signs of tuberculosis in the right apex. The blood, urine and stool examinations were negative. The gastric analysis revealed nothing abnormal. The Wassermann reaction was negative. Three years ago, the patient noticed areas of erythema and pigmentation on the face. The condition steadily progressed until the entire face was deeply pigmented and there was an accentuation of the lines of the skin of the forehead, which suggested a possible early case of lepra. The examination of the nasal cavity revealed no evidence of ulceration.

DISCUSSION

DR. LANE thought the lesion on the face was chloasma and that the others were due to exposure to the elements, a condition which Brocq described as the dermatosis of the sternoclavicular triangle in women who wore decolleté garments continually.

DR. WILLIAMS thought it was chloasma. He recalled a patient whom he had attended, a blonde, in whom exposure to the sun had caused an actual atrophy of the skin over the manubrium and just above.

DR. MACKEE thought that a diagnosis of argyria should be considered.

DR. POTTER said that he had seen the patient three years ago and had thought the condition to be chloasma, and gave little thought to it; but six months ago she had returned and was so much worse that he thought it might have had some other origin. The face seemed to be very much congested and the lines of the skin of the forehead were accentuated, and it might be a very early case of leprosy, inasmuch as the woman was from the West Indies; it was also possible that the tuberculous condition might have some relation to it. He had not thought of argyria, but so far as he knew the patient had never had any treatment that would produce that condition.

PITYRIASIS ROSEA. Presented by DR. TRIMBLE.

The patient was a girl, aged 12 years. The duration of the condition was eight days, and the location was mainly the trunk, which was thickly covered with a papular eruption that was very rough to the touch, almost as rough as a

nutmeg grater. Scattered throughout, were typical buff-colored lesions of pityriasis rosea. The papular condition seemed as if it might be a secondary dermatitis. The patient, however, stated positively that no treatment had been used before applying at the clinic.

DISCUSSION

DR. HEIMANN agreed with the diagnosis.

DR. WINFIELD said that he had seen cases similar to Dr. Trimble's description of the condition, but that in addition to the dermatitis on the flanks one could see the remains of the original lesion. This winter he had seen a number of patients who had a sore throat and fever, and then an eruption of this peculiar form of lesion followed, which made him begin to think that there were two diseases called by the one name—one of them being the classic disease, and the other probably some form of exanthem.

DR. CHIPMAN (by invitation) said that it was very difficult to diagnose pityriasis rosea in its later stages, and this case was in the late stage; but there were two or three patches which seemed to be pityriasis rosea, and, without knowing what treatment had been received, it seemed probable that it was a pityriasis rosea rather than a secondary dermatitis.

DR. POTTER said there were two or three spots on the abdomen that were no doubt fading patches of pityriasis rosea. The rest of the eruption was a secondary dermatitis.

DR. WINFIELD agreed with Dr. Potter.

DR. TRIMBLE said that undoubtedly a secondary dermatitis was present. The patient had been presented to show the distinct nutmeg appearance, with the pityriasis patches scattered through it.

SYPHILITIC OBLITERATING ENDARTERITIS. Presented by DR. TRIMBLE.

The patient, a man, aged 34, stated that he had had a venereal sore in 1911 or 1912, for which he received internal treatment for one or two years. The lesion was followed by a generalized eruption. The condition for the relief of which he had applied, began fourteen months ago with severe pain in the calf of the left leg. A month later, a redness appeared over the toes, extending to the foot and gradually increasing up to three months ago, when the end of the middle toe became gangrenous. The patient had suffered much pain, which had increased recently. As presented, a deep red, congested and swollen area involved most of the left foot, with gangrene of the first phalanx of the middle toe. The right foot seemed unaffected.

DISCUSSION

DR. KLOTZ said that the cases of syphilitic endarteritis which he had seen did not show the marked redness which characterized this case. Before Buerger described his cases, he had seen in syphilitics conditions of blood vessels about which he had been in doubt—the skin was pale and of a livid bluish color and the hands felt quite cold. They were extremely painful. He was therefore more inclined to consider the case to be one of thrombo-angeitis. However, he recalled a similar case in the German Hospital in which he had thought of endarteritis.

DR. WINFIELD said that during the past year he had seen three cases of Buerger's disease—thrombo-angeitis obliterans. One man gave a negative syphilitic history, and the Wassermann test was negative; the other two patients had strongly positive Wassermann reactions and gave a history of syphilis. In the two syphilitic cases, the lesions were red and the feet were very much swollen, highly inflammatory and very painful. Buerger said that the disease never occurred on the fingers—a distinction between that and Raynaud's disease.

DR. LANE said that some years ago he saw a case occurring in a syphilitic patient in whom the Wassermann test was negative. In this particular case there was none of the redness that Dr. Winfield observed in both his cases. The interesting point in the case was that some time before the gangrene came on, the patient had a typical erythema nodosum on the legs. Some time ago Mauriac wrote an article giving syphilis as the etiology of erythema nodosum in some cases. This patient had to have his leg amputated.

DR. POTTER said that the case presented was no doubt one of syphilitic endarteritis obliterans. In Buerger's disease, as the speaker understood that condition, the pain was constant and intense. The disease was almost entirely confined to male Hebrews, and the affected part was generally livid and cold, as Dr. Klotz remarked, whereas in this case the foot was red and hot.

DR. KLOTZ said that in the unilateral cases one ought not to speak of Raynaud's disease. He had studied the early literature very carefully, and that showed a symmetrical occurrence of symptoms to be an essential feature. Anything that was not symmetrical could not strictly be called Raynaud's disease.

DR. CHIPMAN (by invitation) said it would seem that many of these lesions were due to syphilis and others were not caused by that infection. Inasmuch as some of the patients had tuberculosis we might be justified in thinking that some of the lesions were caused by other affections than syphilis. As far as the erythema was concerned, it might be an individual reaction due to varying circumstances, and not a part of the disease itself.

DR. WISE said that in a recent article in *The Journal of the American Medical Association* it was reported that thrombo-angeitis obliterans occurred in Jews and Gentiles alike in Russia, but as Russian Jews were in the majority in New York, that gave the impression of the predominence of the disease in that race in this city. As to treatment, exposing the legs to extreme dry heat would cure some of the cases.

DR. TRIMBLE said he was familiar with Dr. Klotz' description of syphilitic endarteritis, and like him was under the impression that the hands were nearly always cold. Even so, he was in accord with Dr. Chipman that this extreme redness might be individual in this particular case. He felt fairly certain that this was a case of syphilitic endarteritis. He was not so familiar with Buerger's disease as with Dr. Klotz' description of endarteritis, but was under the impression that the former was one in which the veins were involved. If it was a venous stasis, it ought to be livid and blue instead of red. That was one of the reasons for ruling that out. He still felt it was a peripheral syphilitic endarteritis.

DR. MACKEE said that he understood that erythema nodosum was a clinical entity, that the lesions were caused by the streptococcus, that they developed suddenly, were painful and transient. Erythema induratum was a term applied to Bazin's disease. Erythema induratum syphiliticum or Mauriac's disease was a chronic nodose eruption which markedly simulated Bazin's disease but was caused by syphilis and not by tuberculosis.

TUBERCULOUS ULCER ON THE TONGUE. Presented by DR. MACKEE.

The patient was a man, aged 31. He had pulmonary tuberculosis, and tubercle bacilli were demonstrated in the sputum. The Wassermann reaction was negative. The duration of the tongue lesion was three months. A piece of tissue was removed from the ulcer, and not only was there a tuberculous structure but tubercle bacilli were found in the tissue. The lesion was situated on the dorsal surface of the base or root of the tongue, a very unusual location. The ulcer was deep, the size of a silver quarter, punched out, and the margin was soft. The clinical appearance was that of syphilis.

DISCUSSION

DR. WINFIELD said that probably all would have made a diagnosis of syphilis were it not for our present aids, and even so it was possible that the man had a tuberculid and syphilis also. He agreed with the diagnosis.

DR. MORROW (by invitation) said that it was an unusually interesting case. Some years ago the English dermatologists were loath to believe that in this country we had the condition described as "tuberculous gumma"; they were very sceptical. A case of this type would receive antispecific treatment as a therapeutic test.

DR. TRIMBLE said he had seen six or seven cases and had made a very extensive study of several. This, however, was the first one he had seen that was so deeply excavated. The others were superficial and situated on the anterior portion of the tongue.

DR. WHITEHOUSE agreed with what had been said; he would never have thought of the diagnosis from the appearance of the lesion.

DR. LANE said that the finding of tubercle bacilli in the deep tissue settled the question that the lesion was tuberculous, even if the Wassermann test was positive.

DR. WILLIAMS said that it was a very interesting case and certainly suggested a syphilitic condition rather than tuberculosis. It was less "angry looking" than one would expect in a tuberculous condition.

PAPULAR TUBERCULID. Presented by DR. POTTER.

The patient was a Hebrew boy, aged 16 years. When 3 years old, he had had a number of small papular lesions on the face; these gradually disappeared, leaving scars. Since then similar lesions had developed on the hands and forearms. Roentgenograms showed tuberculosis in the right and left apexes.

DISCUSSION

DR. HEIMANN said he had seen this same patient at the hospital six or seven years ago, with lesions like those presented. At that time, the patient was given tuberculin injections. The condition would grow better and then worse, so it was understood there was no direct connection between the alleged tuberculous lesions and the injections. In spite of calling these lesions tuberculous, histologically there was very little ground for it. In his opinion there was no justification for calling it by any other term than necrotic granuloma.

DR. TRIMBLE said that, if he remembered correctly, Dr. Johnston was the one who urged the use of the term necrotic granuloma. In his opinion, the condition spoken of by Dr. Morrow and that described by Dr. Heimann were the same.

The speaker believed that the tuberculin test should be accepted with a grain of salt. He did not believe, however, that 90 per cent. of normal persons would react positively to the tuberculin test. He had employed the Moro reaction on about sixty persons, twenty-three of whom had tuberculosis of the skin—not tuberculids—and all were positive. There were several tuberculids, all of which were positive. There were nine or ten lupus erythematosus cases, only one of which was positive; and a number of syphilitics, none of which was positive. The test was made in the same way every time and was very carefully done, applying the same amount of friction in using the ointment, for two minutes in each case, and the reaction took place in thirty-six or forty-eight hours. All the tuberculosis and tuberculid cases were positive, and several of the controls were positive; and in many of the positive controls it was afterward found by careful clinical examination that the patient had tuberculosis elsewhere. He thought the Moro test a little better than the von Pirquet test, since it seemed to give a less number of positive reactions in apparently healthy persons. From this experience he thought some consideration should be given to the tuberculin test.

DR. JOHNSTON said that there was a large proportion of latent tuberculosis in the whole population. Any one who had studied at the necropsy tables must have been impressed with the large number of tuberculous lymph nodes found. There were too many sources of error to attach a tuberculosis tag on these eruptions. Some of these cases cleared up under hydrotherapeutic treatment alone.

FILIFORM VERRUCA—NEVUS VERRUCOSUS CONGENITA. Presented by DR. POTTER.

The patient was a girl, aged 12 years, who had just come under observation. She stated that she had had the lesions ever since her birth and that her mother thought they were due to the fact that she (the mother) was frightened by a chicken while pregnant. The patient presented these congenital filiform warts all over the body; there were also some flat warts on the left hand and some warty excrescences under the nails of both hands. The case was presented on account of the unusual distribution of the lesions.

DISCUSSION

DR. WISE agreed that the process was a nevus, but said that the occurrence of filiform verrucae with a nevus was most unusual.

DRS. MACKEE AND HEIMANN also agreed with the diagnosis.

DR. WINFIELD reported on the case with peculiar red patches over the body, in which a diagnosis of premycosis had been made. At the suggestion of Dr. Johnston, he had put the patient on a treatment of mixed pituitary and thyroid gland, and the man was now almost well. The itching had stopped, the skin had thinned down, and the redness was disappearing.

CHICAGO DERMATOLOGICAL SOCIETY

Regular Meeting, Feb. 20, 1917

WILLIAM ALLEN PUSEY, M.D., *President*

LEPRA ANESTHETICA. PRESENTED BY DR. QUINN

The patient was a man, aged 26, who was a clerk in a wholesale house. He was a native of British Guiana, South America. The trouble had been present for about two years, first appearing on the left heel, and about a year later the right heel had become involved. The first skin symptoms were noticed on the forehead, as a pale spot which was somewhat depressed. There were large patches on the forehead, on both arms and both legs and on the trunk. The lesions consisted of diffuse areas of brownish red infiltration with marked anesthesia of all the erythematous portions.

DISCUSSION

DR. HARRIS asked if the scaly patches were psoriasis, and thought it would be interesting to have a section made to see if these lesions were really leprosy.

A series of cures had been reported from the Phillippines in which they had used chaulmoogra oil, both by mouth and deep injection.

The absence of active lesions would not prove that the patient did not have leprosy, for many of them had had no active lesions for years. The speaker thought most of the lesions in this case were simply erythematous.

DR. EISENSTAEDT said that there was a nurse who had been in the Riehl Clinic for thirty-three years and during all that time there was at least one leper in the ward, but the nurse was in good condition after nursing them for that length of time.

LICHEN RUBER MONILIFORMIS. PRESENTED BY DR. QUINN

The patient was a man, aged 35, a tinsmith by occupation, and a native of Russia. The trouble had been present about six months.

The lesions were small and papular and arranged in rows along the course of the nerve trunk, extending from the right scapular region to the dorsum of the right hand, along the extensor surface of the upper arm and along the forearm.

DISCUSSION

DR. HARRIS was not prepared to say that it was a lichen planus. He said the only thing he saw that spoke for the disease was the fact that it itched, but it did not show much evidence of scratching. He could not account for the peculiar distribution beginning in the midline on the back and going directly over the course of the nerves. The speaker said he should want to see a biopsy before he would call it a lichen planus. He thought it a so-called *strichförmige* eruption.

DRS. POTTHOFF, HURLBUT, WAUGH, ZEISLER, EISENSTAEDT AND SHAFFNER thought that it was lichen planus.

DR. MCEWEN said he had seen only the arm lesions, not those on the back. It did not strike him as being a typical lichen planus but he thought it belonged in that group.

DR. STILLIANS thought that it was not necessary to find the typical small, flat, angular, shiny papules to make a diagnosis of lichen planus, but that often the diagnosis was made without them. He considered this case lichen planus.

DR. PUSEY thought the case was not one of lichen ruber moniliformis. Moniliform meant beadlike, not linear. This eruption was not beadlike, but it was simply arranged in lines. The cases of lichen moniliformis that had been described were symmetrical, often extensive eruptions. This case was confined to one part of the arm and shoulder and bore no close resemblance to the cases of generalized eruption which had been described as lichen ruber moniliformis. The speaker thought it a very interesting case on account of the peculiar linear arrangement and called it an illustration of the striking pictures that lichen planus could produce. On the back of the hand, there were many umbilicated, typical lichen planus lesions, and the patch on the back of the hand as a whole was a lichen planus patch.

DR. HARRIS said there were published whole series of pictures of the *strichförmige* eruption of acquired lesions coming on like this and lasting for several months and then going away. The lesions had been separated from the lichen planus group.

DR. QUINN thought that the poorest place to study the case was on the back of the hand. He believed that was aggravated by the man's occupation, but the lesions on the arm and back were not influenced in that way. He thought most of the lesions on the back of the hands were the kind that any worker would have. He did not consider the color at all typical of lichen planus. Most of it was dark red. Over the hands it might be slightly purple but most of that was a dermatitis due to the patient's occupation plus the inflammation along the nerve. The speaker thought the nearest case to this one that he had ever seen was one Dr. Hyde had called lichen ruber moniliformis.

ERYTHEMA OF THE UPPER LIP. PRESENTED BY DR. HARRIS

The patient was a man, aged 28, who had been shown before, having been under treatment ever since the previous examination without improvement. The lesion had been present for about four years and consisted of redness of the upper lip which was strictly confined to the hair line, and showed no papules, or pustules, or infiltration. A diagnosis of seborrheic dermatitis had been suggested.

DISCUSSION

DR. QUINN thought it a very interesting case but did not venture a diagnosis.

DR. SHAFFNER thought it looked like ulerythema ophryogenes, which more commonly occurred on the eyebrows.

DR. EISENSTAEDT said that he agreed with Dr. Shaffner, also that the condition had been present long enough, although it did not show atrophy nor alopecia. For that reason he thought that the expression "erythema sycosiforme" would express the clinical picture.

DR. PUSEY thought the location of the eruption made it highly probable that the process had to do with the follicles of the mustache. As the eruption was absolutely limited to the hair area of the upper lip, this made him feel that the process was a subacute folliculitis of the mustache hairs. It might be a *Staphylococcus albus* infection, for example, or a seborrheic dermatitis. He offered this simply as a suggestion. He did not pretend to make a positive diagnosis of folliculitis.

DR. HARRIS said the whole lip had been epilated and treated with white precipitate ointment and again with sulphur, but the erythema remained. He had then lost track of the man, who had returned the day before with just the same condition. The symptoms did not bother the patient except for the appearance. There had been no abscess or folliculitis that could be seen. He said he should like to make a biopsy but was afraid it would leave a scar. He thought it was unquestionably a folliculitis but did not know what the infection was. At times it was somewhat scaly.

MERCURIAL STOMATITIS. PRESENTED BY DR. HARRIS

The patient was a woman, aged 34, who had worked for five years as a nurse in the syphilitic ward of the county hospital. A year and a half previously, she had first had trouble with her teeth, which came on suddenly and was supposed to be pyorrhea.

Examination showed a gingivitis around all the teeth of both jaws, with a necrotic membrane, typical of a mercurial stomatitis. There was no history of the patient having taken mercury but she had worked in the syphilitic ward for five years where mercurial inunctions were constantly being used.

DISCUSSION

DR. MCEWEN had seen the patient in an attack a year previously, at which time the lower front teeth were involved. He did not recall that the other teeth were affected. He thought the condition presented was much more extensive and severe than the previous one. He was sure that the patient had lost weight recently.

DR. HARRIS said the dentist who had been treating the patient told her she had syphilis. The gums were separated from the teeth and badly swollen. She had had the condition for more than a year. When she was in the erysipelas ward for three or four months, she had not been troubled with it. She had been head nurse in the syphilitic ward for a time and was not as closely associated with the patients as previously. The condition was not present then, but when she had returned to the ward as a nurse, it had become more pronounced.

PHILADELPHIA DERMATOLOGICAL SOCIETY

Regular Meeting, May 21, 1917

HENRY K. GASKILL, M.D., *Chairman*

URTICARIA PIGMENTOSA. PRESENTED BY DR. HARTZELL

The patient was a white woman, aged 26. For the past seven years she had been noticing a small, flat papular eruption on various parts of the body. At the time of presentation there were about seven to ten lesions of this

type on the flexor surfaces of each arm, very slightly elevated and brownish in color. There had been very few on the face and on the legs but there was none on those parts when presented. There was not and never had been any itching nor any artificial dermatographia demonstrable. The diagnosis was made very largely by biopsy, a large number of mast-cells being present. Dr. Stelwagon said that from the superficial examination, he would be inclined to think of a disseminated lupus but agreed with the diagnosis.

RHINOSCLEROMA UNDERGOING MALIGNANT CHANGE. PRESENTED BY DR. STELWAGON

This patient was shown at the Philadelphia Dermatological Society, Oct. 16, 1916, with the report as follows:

"Rodent Ulcer Following Rhinoscleroma. Presented by Dr. Stelwagon. J. F., a white woman, aged 52, was presented before this Society on Nov. 11, 1911, with an unchallenged diagnosis of rhinoscleroma. She had been treated with roentgen ray and the tissue had broken down. Radium was afterward used but the tissue continued to break down beyond the point of application, until at the time of presentation the entire nose was gone as well as the upper lip. A piece of tissue was excised by a member of the pathologic department of Jefferson Hospital, and the diagnosis made of basal cell epithelioma on a gummatous syphilid, with numerous spirochetes in the tissue. Several doses of salvarsan had made no impression on the lesion. Comment was made about the finding of the numerous spirochetes in this gummatous tissue."

In the eight months which had intervened, the malignant process had extended much more deeply until the entire nasal cavity had been destroyed. However, there was none of the raggedness of ulceration, the lesion being well defined and clean-cut, looking more as if the tissues had been scraped out of a mold of red putty rather than removed by a degenerative process. Around the margins, the cheeks were very hard and boardlike and in the same condition as was her nose when first seen in 1911. The glands of the neck were very much enlarged on both sides and particularly so on the right, and in one place were almost ready to break down. Apparently it was only a question of a short time when there will be a general disintegration of all the glandular structures in that vicinity.

CASE FOR DIAGNOSIS. PRESENTED BY DR. HARTZELL

The patient, M. C., aged 56, was presented at a previous meeting by the speaker. This case had been presented as one of a generalized dermatitis but it was recalled that the patient had been originally shown five years previously with a typical eruption of dermatitis herpetiformis, but this time it bore absolutely no resemblance to that disease. The patient was covered with a marked scaling eruption on a mildly inflammatory, very much indurated base and extending over the entire body, accompanied by intense itching. At the time of presentation, this eruption was not uniform but assumed, in certain places, an annular form. These rings could be distinctly seen in a good light and were mainly of an erythemato-papular type, though the speaker said at times he had seen vesicles. There was apparently some slight improvement but no amelioration of the intense itching. On the neck, there was a marked tendency to keloidal formation though this manifestation was not observed on any other parts of the body and was of recent formation. The suggestion was made that we might have to do with the premycotic stage of a mycosis fungoides.

CASE FOR DIAGNOSIS. PRESENTED BY DR. STELWAGON

This patient was a white man, aged 22, who stated that two years previously, he noticed an eruption over the left hip and, according to his statement, a lesion once formed never disappeared. At the time of presentation, his body from the level of the eighth rib to half way down the thigh was irregularly covered with various sized and various shaped lesions. Some were ring-shaped

and still others in the form of a figure 8 or in fanciful contours. The older lesions showed considerable induration but this did not occur in the more recent ones. All were distinctly and sharply elevated above the surrounding skin with no surrounding areas of inflammation. The color of the more recent lesions was a pinkish brown and on the older ones, much more distinctly brown. On many of the lesions there were pea-sized nodules superimposed. There was no associated itching. The patient had applied for enlistment in the Navy and on account of the unusualness of the eruption had been referred to the speaker, who believed that the case was one of erythema perstans but that it was not possible at the present time to ignore an additional diagnosis of leprosy, in spite of the fact that there were no areas of anesthesia.

NEW YORK ACADEMY OF MEDICINE, SECTION ON DERMATOLOGY

Regular Meeting, April 3, 1917

GEORGE M. MACKEE, M.D., *Chairman*

HEMORRHAGIC SARCOMA OF KAPOSI TREATED BY THE ROENTGEN RAY. Presented by DRS. MACKEE AND REMER.

M. L., man, aged 62, had been presented about two years ago, at which time the disease affected the hands, feet and both the extensor and the flexor surfaces of the forearms and legs. The lesions consisted of diffuse, purple, indurated and raised plaques, some of which were reddened and inflamed and others quite flat and on a level with the normal skin. In May, 1915, there developed on the sole of the left foot an elevated, boggy, ulcerating lesion, about the size of a dime. The hands were swollen and edematous and there was severe pain. The roentgen ray was applied to the lesions on the palms, an average dose of 6 skin units—24 Holzknecht—being given. The lesions on the dorsum of the hand and extensor surfaces of the arms received 7 skin units—28 Holzknecht. The lesion on the foot, one treatment consisting of 3 skin units—12 Holzknecht. All the treatments were filtered through 3 mm. of aluminum.

DISCUSSION

DR. WISE said that Dr. Remer had failed to impress on the members of the Section the fact that this man suffered a great amount of pain which made it impossible for him to go to work. A few roentgen-ray treatments caused complete cessation of the pain.

DR. MACKEE said that the lesion on the sole of the foot which Dr. Remer referred to, was growing very rapidly when they first saw the patient and it had more the appearance of a pigmented sarcoma. They thought, from the rate at which the lesion was increasing in size, that the end was near, and were both pleased and surprised to see the lesion clear up under one rontgen-ray treatment.

EPITHELIOMA AND RADIODERMATITIS. Presented by DRS. MACKEE AND WISE.

N. D., male, aged 45, married, born in Russia, was from Dr. Fordyce's service. Nine months ago, a small, hard nodule appeared on the left cheek, below the eye. This was cauterized and remained well for a short period. After several months, the lesion recurred in situ and was then treated, according to the patient's statement, by means of six exposures to the roentgen ray, the last of which was administered three weeks ago. The patient presented a slightly depressed lesion, about three-fourths inch in diameter; the surface was dry, and the edges were nodular. Surrounding this ulcer was an area of erythema and swelling, appar-

ently provoked by an irritating application, or possibly produced by the heat of an active roentgen-ray tube.

DISCUSSION

DR. ROSEN said that when he examined the patient, about four weeks ago, the lesion presented an entirely different appearance. It was circular in outline, more or less sharply circumscribed, with a deep infiltration of the tissues extending about one-half inch outside its circumference. The base was covered with a thick crust caused by the various ointments which had been applied. The speaker said his first impression was that the lesion was either an epithelioma or gumma. The Wassermann reaction at two different times was + +. He recommended antisyphilitic treatment, and externally, emplastrum hydrargyri and thought it was the mercurial plaster that caused the dermatitis which was present when the patient was shown.

DR. REMER said that the patient stated that he had had six roentgen-ray treatments, each of fifteen minutes' duration, with the tube almost in contact with the skin. If his last treatment had been given three weeks ago and of fifteen minutes' duration, the speaker thought that the dermatitis might be an erythema produced by the roentgen ray.

DR. MACKEE said that the patient presented a rather confusing condition. It did not look, if he could speak personally, like an ulcerating radiodermatitis, unless it was one that had run its course and was healing. It was difficult, clinically, to tell what had caused the irregular ulcer. There was a walnut-sized, deeply-seated nodule near the nose. When the speaker saw the patient a few days ago the nodule was hard; when presented before the Section it was soft. It would be necessary, he said, to watch this case and be careful about the diagnosis.

ACTINOMYCOSIS CURED BY THE ROENTGEN RAY. Presented by DR. REMER FOR DR. STEINKE.

M. S., woman, aged 20 years, married, had one child who died when 1 year old. The patient's father was dead. Her mother, two sisters, a brother and her husband were living and in good health. When a child, she had had whooping cough and measles, otherwise she had been in good health until May, 1916, when she noticed a swelling on the left side of her face as if caused by an ulcerated tooth. The swelling did not subside so she visited the hospital, on two occasions, about the middle of June and had the abscess incised. When first seen, July 23, 1916, there was an irregular inflamed lesion on the ramus of the left jaw, extending from the angle of the jaw to about 3 inches forward toward the symphysis and about 2 inches wide. This showed a number of craterlike projections with pus discharging from the openings, the areas in between being red and inflamed, tender to the touch but otherwise not painful. There were no lesions on the inside of the mouth and a roentgenogram of the lower left maxilla revealed no involvement of the bone. The pus from the lesion was examined microscopically at the Dermatological Laboratory of the Vanderbilt Clinic and the ray fungus was demonstrated.

July 24, 1916, the patient complained of pain in the lower extremities and walked with a slight limp. There was slight nausea but no vomiting. August 2, the pain in the lower extremities was more severe with some swelling of the right elbow. She was admitted to the hospital, August 4, with an aggravation of all the symptoms, the right elbow very much swollen and painful but with no sign of any inflammation. A roentgenogram was taken but it was negative as also was an examination of the chest, abdomen, kidneys, blood and a Wassermann test. September 1, the lesion showed a decided improvement, only a small amount of pus discharging from its lower angle near the symphysis, the remainder of the lesion was dry and all signs of inflammation had disappeared. She remained in the hospital until September 3, 1916, when she was discharged, the lesion being healed. During her stay in the hospital she had received no treatment of any kind and the cure was attributed to the one roentgen-ray treatment.

When the patient was presented before the Section the lesion had entirely disappeared, leaving an irregular and somewhat keloidal scar. A second roentgen-ray treatment had been given in the hope of reducing the hypertrophied scar. Potassium iodid had never been administered.

LUPUS ERYTHEMATOSUS OF THE LOWER LIP. Presented by DR. BECHET.

The patient was from Dr. Trimble's service at the University and Bellevue Clinic and had been shown before the March meeting of the Section with a similar diagnosis. At that time one of the members thought the lesion was syphilitic and suggested further specific treatment; since then the patient had been given one injection of 0.3 gm. of salvarsan and from one-eighth to one-sixteenth grain of bichlorid of mercury, three times daily, by mouth. There had been no change in the appearance of the lesion. The patient was shown again with the same diagnosis.

DISCUSSION

DR. BECHET said this case had been shown at the last meeting and Dr. Lapowski thought it was syphilis; two other physicians agreed with the diagnosis of lupus erythematosus. When he first saw the case he thought it was syphilis, but later changed the diagnosis to lupus erythematosus, because the appearance of the lesion, on more extended observation, seemed to coincide more with lupus erythematosus than syphilis. Its resistance to specific treatment seemed also, in all probability, to exclude syphilis.

DR. TRIMBLE said that this patient had been under observation at the University and Bellevue Clinic for some time. At first, the differentiation between syphilis and lupus erythematosus could not be made. He was, however, at the patient's first visit in favor of the former diagnosis. The Wassermann reaction had been repeatedly negative; and from the fact that very little improvement had occurred following the administration of mercury and the iodids, they had about reached the conclusion that the lesion was one of lupus erythematosus.

LYMPHANGIOMA CIRCUMSCRIPTUM. Presented by DR. TRIMBLE.

The patient was a young girl, aged 15 years. The lesion was first noticed by the patient when she was 8 years old and had increased in size slowly since that time. At the time of presentation it was about the size of a half-dollar, and consisted of a plexus of dilated lymph vessels. Outlying lymph vesicles could also be observed.

URTICARIA PIGMENTOSA. Presented by DR. GOLDENBERG.

The patient, Fannie W., aged 23, was born in Austria. She was married, had one child living and had had no miscarriages. The family history was negative. Six years ago, after her arrival in this country, an eruption appeared on the extensor surface of both hands. This eruption spread until the entire body became affected, including the face and neck. The patient presented a generalized macular eruption, the lesions varying in size from a split pea to that of a small bean and of a light brown to a yellowish brown color. Friction over these pigmented spots resulted in the appearance of an urticarial wheal. The lesions did not disappear. The only subjective symptom was slight itching at times but there was no evidence of any scratch marks.

DISCUSSION

DR. HEIMANN said that this eruption belonged to a group of rare dermatoses that were not well defined. Urticaria pigmentosa began in infancy and usually disappeared during adolescence. He could not say whether or not a histologic examination would be of any real value in Dr. Goldenberg's case. He imagined that the histology would show a subacute inflammation similar to that found in the erythema perstans group. If this were so, Dr. Goldenberg's case he thought,

should be designated as a pigmented urticaria rather than urticaria pigmentosa—a name which had been given to a definite clinical entity, was also called xanthelasmoidea, which histologically showed an infiltration made up almost exclusively of mast cells.

DR. TRIMBLE said that he did not think we should be too dogmatic about a classification. He was willing to accept as urticaria pigmentosa cases that developed in adolescence and even in adults. As an analogy he mentioned syphilis hereditaria tarda, the acquired type of epidermolysis bullosa and xeroderma pigmentosa. This last affection, when known to be congenital was spoken of as xeroderma pigmentosum, and when it appeared in adult life it was called sailor's skin. This was a distinction without a difference; adult cases having practically all the symptoms, such as telangiectases, keratoses, malignant freckles, etc., were in his opinion cases of xeroderma pigmentosum, and this reasoning could apply to a number of other affections.

DR. WISE said that he agreed with Dr. Trimble. Furthermore, he did not think that the history of Dr. Goldenberg's case was reliable. It was possible that the girl had had lesions in childhood that had been overlooked. The speaker said that he had seen cases of urticaria pigmentosa which had developed in adult life and which under the microscope showed an infiltration consisting of mast cells.

DR. HEIMANN said that he did not make the statement that this was not a case of urticaria pigmentosa. If under the microscope mast cells were present, it was a case of urticaria pigmentosa. If not, then it must be placed in the other group, namely, pigmented urticaria.

DR. MACKEE said that he also agreed with Dr. Trimble that there was no reason why urticaria pigmentosa should not occur in adolescent or even in adult life. Nevertheless he personally had seen no cases that had not begun in childhood. He thought that clinically this case differed somewhat from the classic picture seen in urticaria pigmentosa. In the latter the lesions were larger, irregularly elevated and outlined and the color was not that of ordinary pigmentation as seen in this case, but was a yellowish or yellow-brown color, resembling the color seen in xanthoma. Clinically, he was inclined to agree with Dr. Heimann and favored the tentative designation of pigmented urticaria. A biopsy, of course, would settle the diagnosis.

TUBERCULOSIS VERRUCOSA IN A SYPHILITIC. Presented by DRS. MACKEE AND ROSEN.

The patient, N. M., man, aged 29, a native of Greece, was treated by Dr. Fordyce at the City Hospital. He presented a large serpiginous lesion on the buttocks which first appeared nine months ago. The penis exhibited several small scars, said to have been the sites of chancres. Examination of tissue from the lesions on the buttocks revealed a typical structure of tuberculosis. The Wassermann test was + + + and the antisyphilitic treatment had little if any influence on the disease of the skin. From a clinical standpoint, the serpiginous lesions of tuberculosis cutis were indistinguishable from those of syphilis, but there was no doubt as to the microscopic picture of tuberculosis in the excised section of skin.

DISCUSSION

DR. HEIMANN said that he had examined the specimens and could certify that while he had not been able to demonstrate the tubercle bacillus, the general structure was certainly that of tuberculosis. This, together with the fact that the lesions did not respond to vigorous antisyphilitic treatment, would tend to confirm the diagnosis of tuberculosis.

DR. MACKEE said it was well established that it was sometimes impossible to differentiate clinically and sometimes even histologically between tuberculosis and syphilis of the skin. He recently presented a case before the Manhattan Dermatological Society of an infiltrated plaque on the posterior aspect of the right

leg of a young girl. The plaque was of a deep-brownish color and had a scalloped border in which there were four punched-out ulcers. Everyone unhesitatingly made a diagnosis of syphilis. But histologically, however, the picture was very distinctly that of Bazin's disease. Furthermore, the patient did not improve under vigorous antisyphilitic treatment but the condition did yield at once to roentgen-ray treatment. Such cases taught one to be extremely careful in making diagnoses.

DR. ROSEN said the patient had received two courses of salvarsan, eight injections each time, the average dose being 0.35 gm. and altogether thirty mercury salicylate injections intramuscularly. The lesions had not responded to this energetic treatment. A biopsy had been made and the pathologist reported tuberculosis. The patient was then referred to the roentgen-ray department for treatment and after a few treatments the lesions had begun to involute.

DR. TRIMBLE said that clinically he would regard the case as one of syphilis. The fact that there was no verrucose element, and that active ulceration was going on, would lead one away from the diagnosis of tuberculosis; the festooned border was also characteristic of syphilis. Furthermore, the lesion was only of one month's duration, and it seemed almost impossible that a lesion of tuberculosis could grow so rapidly.

SYCOSIS BARBAE, FOLLICULITIS OF THIGHS ASSOCIATED WITH A PECULIAR ALOPECIA. Presented by DRS. MACKEE AND HEIMANN.

M. R., a man, aged 42, from Dr. Fordyce's Clinic, presented an ordinary sycosis of the beard, which had existed seven months. The skin of the thighs, especially the anterior surfaces, also showed marked evidences of infection of the hair follicles. About the genitals, however, was a sharply circumscribed area presenting a striking absence of hair—in other words, an alopecia. The skin in this area was perfectly smooth and free of all evidences of hair growth. The appearance was that of an area recently depilated by means of the roentgen ray or a chemical depilating agent; but the patient gave no history to confirm this suspicion. It was not possible to ascertain the actual cause of the alopecia. Examination for the tinea fungus was negative.

DISCUSSION

DR. TRIMBLE said that he agreed with the diagnosis of sycosis. He thought that the condition on the thighs and lower abdomen was the same as that on the beard. He also thought that the alopecia was due to some form of treatment. The patient had told him that a salve had been used and the speaker thought that this salve might have been a depilatory.

DR. PAROUNAGIAN agreed with the diagnosis of sycosis and thought that perhaps roentgen-ray treatment had caused the loss of hair.

DR. MACKEE said that the very complete alopecia certainly suggested some application as a causative factor. However, he noted that the alopecia both on the thighs and in the pubic region was only in the cured areas and that the hair was growing at the active margin, where there was a pronounced papulo-pustular folliculitis. Although doubtful, it might be, nevertheless, that the loss of hair was due to the destruction of the hair follicles by the follicular suppuration. In appearance the bald areas certainly looked as though they had been shaved. The speaker said he did not understand why the question of parasitic sycosis had been suggested as the case had all the appearances of an unusually widespread sycosis vulgaris.

ERYTHEMA MACULATUM PERSTANS. Presented by DRS. MACKEE AND WISE.

The patient, S. A., man, single, aged 45, from Dr. Fordyce's Clinic, gave a history to the effect that the lesions began three years ago and persisted until December, 1916. They consisted of smooth, flat, reddish and violaceous macules,

located on the arms, legs, buttocks and scrotum. On the scrotum, the surface of the lesions was somewhat moist and eczematous in appearance. In December, a fresh outbreak of reddish patches occurred, most of them reappearing in the same sites as on the previous eruption. These patches would persist for weeks or months, without showing signs of involution. They were uninfluenced by ordinary forms of treatment.

DISCUSSION

DR. ROSEN said he could not understand, looking at the case for the first time, a diagnosis of erythema multiforme perstans. There was a moist eczema of the scrotum extending between the gluteal folds, with slight scaling and cracking. The diagnosis he would consider would be chronic eczema.

Dr. Abramowitz (by invitation) said that he thought that the eruption was an eczema. The lesions on the scrotum and thighs certainly looked like eczema.

DR. MACKEE said that the lesions were too sharply marginated to be an eczema. The lesions on the scrotum and thighs were eczematous and in that sense they could be called an eczema—a secondary eczema. The lesions on the other parts of the body were of sudden onset, erythematous and sharply marginated.

DR. WISE said the case would have to be presented again before a definite diagnosis could be made and that he would present the patient at a future meeting.

CHILD WITH SCLERODERMA IMPROVED UNDER THYROID EXTRACT. Presented by DR. OULMANN.

Ph. A., boy, aged 4 years, was presented at two previous meetings with the diagnosis of polyglandular syndrome. When last shown before the Section, the boy presented almost normal skin. The warty excrescences on the joints of the wrists, knees and especially over the hip had disappeared, as well as the rhagades. The myxedematous skin of the trunk and extremities presented only a slight puffiness on the latter, while the scleroderma-like infiltration of the skin had changed to normal. The mental condition was also normal. The roentgenogram still revealed an enlargement of the thymus and the retardation of bone formation still existed. Some epiphyses not present before had developed. The treatment had consisted in the administration of one-half grain of extract of thyroid.

DISCUSSION

DR. WISE said that he had seen this patient on two occasions and that the condition was a very unusual one. The child had had a series of hard nodules on the outer surfaces of the thighs and on the buttocks. These nodules had disappeared apparently as the result of thyroid therapy. The speaker said that he did not know whether these nodules were a part of the symptom complex of myxedema or whether they could be placed in the category of scleroderma. The result of the medication in such a short time was very striking.

DR. HEIMANN said that every time he saw this case he was more perplexed. At first he thought it was cretinism. Then he favored scleroderma, particularly since Dr. La Fétra, at a previous meeting, favored this view. At first, thyroid therapy seemed to do no good. Later, however, there was distinct improvement. The speaker said that he would like to hear Dr. Satenstein speak about glandular therapy in this case. There seemed to be two well-defined groups of scleroderma: one group appeared to respond to thyroid therapy; the other to pituitary extract. One type was distinctly scleroderma, while the other was more a condition of cretinism or myxedema but resembling scleroderma. In the one type there seemed to be a deficiency on the part of the thyroid gland, in the other a pituitary deficiency with increased sugar tolerance. The speaker recalled a patient who was able to ingest 300 gm. of sugar before developing glycosuria—one and one-half times above the normal. This indicated hypopituitarism, although pituitary medication failed to decrease sugar tolerance.

DR. SATENSTEIN (by invitation) said that it was well known that myxedema did not occur before puberty, understanding by myxedema, a degeneration of physiologic normal tissue; whereas transitory edemas of various degrees and persisting for varying lengths of time did occur at any age in the so-called thyroid insufficiency. He would classify the case presented under this heading. To answer Dr. Heimann, it seemed to the speaker that there were cases classified as scleroderma which were really types of myxedema, in which partial absorption of the degenerated tissue had begun and that these were the cases that responded to the thyroid therapy, whereas the cases that showed true sclerodermatous tissue under the microscope, did not respond to the thyroid therapy. The speaker said that he did not understand the difference but only related the facts as he saw them. He also stated that disturbed sugar tolerance was almost always present in cases of thyroid insufficiency.

CHRONIC ECZEMA IN A SYPHILITIC PATIENT. Presented by DR. GILMOUR.

The patient, J. D., was a man, aged 26, married, born in the United States and worked as a clerk. The family history was negative. The patient denied syphilis and no history pointing to that disease could be obtained excepting that when a young man he had a mild case of gonorrhea which disguised, perhaps, a primary lesion. The disease started as papules with thickening. The condition had been present for the past six or seven years on the finger tips but had never been quite so extensive. There had never been more than moderate itching. Water coming in contact with the fingers made the condition worse. When the patient was in the country in the summer, the lesions disappeared. There had been no treatment for several weeks to modify the condition which was present when the patient was exhibited before the Section. The Wassermann reaction was + + +.

On the right hand, the skin on the palmar surface of the distal phalanx of the thumb and all the fingers, except the little finger, was thickened and was of a slightly verrucose character. The surface was deeply cracked but there was no bleeding. The surface of the affected area had a slight black tinge. This thickening extended under all the finger nails. The hypothenar eminence of the right hand was slightly thickened and scaly. A similar condition existed on the same area and in the location on the left thumb, the left index and middle finger. The border of these lesions was sharply defined. On the backs of the heels there was a moderate thickening but it was not cracked or verrucose in character. A line of thickening three-fourths inch broad extended on the sides of both feet from the heels to the toes. This line was just above the outer palmar surface which bore the weight of the body.

DISCUSSION

DR. BECHET said that he thought the lesions were too sharply defined with scalloped edges, and raised, dry, fissured surfaces to be eczema. He had seen a number of cases of bilateral syphilis of the heels and soles, which looked exactly like the lesions in Dr. Gilmour's case. For these reasons he believed the lesions were syphilitic and not eczematoid.

DR. MACKEE said that the marked and adherent horny layer, the markedly thickened skin, the rather sharp limitation and rather sharp margins with irregular outlines, suggested the possibility of syphilis in spite of the fact that the eruption was bilateral and symmetrical. He would not be willing to hazard a diagnosis between the two diseases in this case.

DR. GILMOUR said that he had seen a syphilitic eruption resembling this one on the foot and especially on the heel. He still favored a diagnosis of eczema.

DR. ABRAMOWITZ (by invitation) suggested a diagnosis of keratodermia blennorrhagica.

MANHATTAN DERMATOLOGICAL SOCIETY

Regular Meeting, March 9, 1917

FRED WISE, M.D., *Chairman*

NODULAR SYPHILIS OF THE GLANS PENIS. Presented by DR. PAROUNAGIAN.

The patient was an Armenian, aged 25, employed in a spoon factory. The duration of his trouble, which was on the glans penis only, had been about nine months. He denied intercourse and any venereal history. The lesions consisted of elongated and traverse scars, eight or ten in number, on the glans penis. When the exhibitor first saw the patient, February 12, there were three dark reddish, elevated nodules and two large, comedolike, active lesions; all the remainder were scars. The possibility of the affection being tuberculosis or syphilis was thought of, although none of the lesions resembled either disease. The Wassermann reaction was + + + +. Thereupon salvarsan was administered, which removed the nodules and benefited the condition greatly, the old scars remaining.

DISCUSSION

DR. HOWARD FOX said that when he saw the case, several diagnoses were considered, including a nodular syphilis, tuberculosis and chancroid. There were several distinct, hard nodules, several ulcerations and punched out scars. The absence of pain and inguinal adenopathy and the long duration spoke against the diagnosis of chancroids. The tentative diagnosis of syphilis was later shown to be correct from the result of treatment.

TUBERCULOSIS CUTIS, SCROFULODERMA, SYPHILIS AND LICHEN SCROFULOSORUM. Presented by DR. PAROUNAGIAN.

The patient, Mr. M. M., an Armenian, aged 32, had been presented before the Society at the January meeting, with the diagnosis of syphilis of the nose, scrofuloderma, and tuberculosis of the lower extremity. As the opinion of the majority was that the entire eruption was syphilis, the exhibitor administered six salvarsan and six mercury salicylate injections, without any improvement in the skin manifestations. Through the courtesy of the Vanderbilt Clinic, a biopsy was made from the leg lesions and Dr. Satenstein reported tuberculosis cutis of the sarcoid type. As the condition was not improved by the vigorous antisyphilitic treatment and in view of the miscropic picture, the speaker regarded the whole condition a tuberculous process. As to the eruption on the body, it was believed to be due to potassium iodid and salvarsan, though after careful examination a diagnosis of lichen scrofulosorum was made and confirmed by microscope.

Description of the eruption on the body: The lesions of lichen scrofulosorum were confined to the trunk mostly, and a few lesions were noticed on the arms and upper portions of the thighs. The lesions were small, grouped papules, situated at the orifices of the follicles. Some had scaly tops, reddish in color. They were most pronounced on the sides of the chest. The lesions at the sacral region had shining, flat tops, violaceous in color, somewhat resembling lichen planus. There was no noticeable itching and the duration was about four or five weeks.

DISCUSSION

DR. MACKEE said that he had, at the time of the previous presentation, thought that the leg lesions were syphilitic and that the scars on the body might be the remains of syphilitic or scrofulous gummas. The fact that the leg lesions had not improved under the influence of mercury, iodid, and salvarsan would rule out the diagnosis of syphilis. And the fact that the nose lesion had developed in spite of this treatment would tend to show that it, too, was

tuberculosis. Assuming that the lesions were tuberculous, both the nose and leg lesions could in all probability be classified as tuberculosis verrucosa cutis and the large, deep-seated scars on the chest were probably the remains of scrofulous gummas. The feature that interested the speaker most was the eruption on the trunk. This eruption was of recent development, it was papular and the papules were intimately connected with the hair follicles. On account of the grouping the eruption resembled, at first glance, a follicular syphilid. But the papules were flat topped and shiny instead of accuminate. Dr. Parounagian thought that this eruption was due to iodid of potash, but the speaker had never seen or heard of a follicular, papular eruption following the ingestion of iodid, although such an occurrence might be possible. The speaker agreed with Dr. Gottheil that the eruption represented a lichen scrofulosorum, developing in an adult.

DR. MOUNT said he believed the lesions, which were small, follicular papules in groups, on the chest, back and other portions of the body to be lichen scrofulosorum. He saw no reason, in an individual of that type, suffering with manifest tuberculosis in other parts of the body, why it should not be lichen scrofulosorum.

DR. SATENSTEIN said that the microscopic appearance of tissue taken from the lesion on the leg was distinctly tuberculous. There was absolutely nothing there to indicate either syphilis or lichen planus. As to the lesions on the body, he agreed with the remarks of Dr. MacKee. They must start sometime and probably were present for a long time but had not been noticed. The inflammatory reaction accompanying those lesions was, in all probability, due to the salvarsan and potassium iodid that the patient had received. It was nothing unusual for existing lesions of various types to be irritated by the administration of the drugs mentioned.

DR. OULMANN said that when Dr. Parounagian first presented the case and maintained the process on the legs was tuberculous, he thought it might be Bazin's disease. He did not say that the man might not have had syphilis besides.

DR. HOWARD FOX thought the case was especially interesting on account of the presence of an eruption that resembled lichen scrofulosorum. The rest of the eruption he considered to be lupus. He called attention to the fact that numerous cases of lupus had of late years been shown in New York, of widely different clinical types. Some of these were totally different from the ordinary picture of lupus occurring on the face.

DR. WEISS said the case fitted very well with tuberculosis, that there were here multiple ulcerations, most probably due to a scrofulodermatous condition. There was a broken down tuberculosis of the legs and as a corollary to it, lichen scrofulosorum, and he thought that these four conditions clinically, at least, identified the diagnosis.

DR. HOWARD FOX asked if any one could explain why we saw so few cases of lichen scrofulosorum in this country. Such cases were recorded in the foreign journals much more frequently than here. Whether we failed to recognize cases or whether they were really very rare, he was not sure.

DR. GOTTHEIL said he had seen one of these cases a good many years ago, in which Dr. Robinson had also made the diagnosis.

DR. WEISS thought the condition was largely due, in individuals so disposed, to perspiration and wearing an infrequent change of heavy underwear. In persons with the so-called tuberculous habit, excessive sweating was the order. Under the influence of warmth and moisture the development of lichen scrofulosorum was assisted. As people here had better environment, healthier conditions, more frequent change of underclothing, one did not meet the dermatosis so often.

LUPUS VULGARIS. Presented by DR. OULMANN.

The patient was an adult woman, who six years previously developed some brownish-red, symmetrical lesions on both legs. They were then the same size as when shown and were larger on the right leg than on the left. She had a few roentgen-ray treatments which made the skin a little paler. The lesions came out at once and remained unchanged. The speaker regarded the condition as lupus.

DISCUSSION

DR. GOTTHEIL said he saw nothing but stains on the skin, which might be due to an inflammatory cause.

DR. SATENSTEIN said that the lesions looked a good deal like the staining following carbolic acid burns. He suggested malingering as a diagnosis and advised microscopic examination of tissue from the lesions.

DR. MACKEE thought that a diagnosis of malingering should be considered. Carbolic acid might leave pigmentation that sometimes endured for months and years.

DR. WISE said he was strongly against making a diagnosis of malingering of six or seven years' duration in a young woman of the type presented. In such cases, evidences of hysteria and mental aberration were usually manifested. The self-inflicted lesions most often appeared on the arms and chest.

DR. OULMANN said the patient had oblong lesions when she first came to him and they were more reddish at that time. They became browner under the application of the roentgen ray. Some parts of the lesions turned paler, almost white. She had a tuberculous condition of the lungs. He regarded the case as lupus vulgaris even if he did not make out distinct lupus nodules at the time. The lesions never were ulcerated and there never was any change in the skin, until she came under treatment.

CASE FOR DIAGNOSIS. Presented by DR. OULMANN.

The patient was an adult woman, whose lesion had existed for about six months, on the outer side of both feet, below the malleolus. In these regions the patches exhibited a red rim, and in the front part the rim went over into erythematous plaques and a few telangiectatic lesions. As the lesions of Majocchi's disease had been discussed so much recently, the speaker presented this case for an opinion as to its being related to that dermatosis.

DISCUSSION

DR. SATENSTEIN said the patient had given some other facts. She stated that her glands were occasionally swollen and stiff, especially in the morning. He regarded this case as a disturbance of the endocrine system, similar to the angioneurotic edema presented by Dr. Ochs at the last meeting. Probably the direct cause was an insufficiency of the suprarenal glands due to an insufficiency of the thyroid. The thyroid was palpably enlarged. The speaker said that there were some dermatological conditions to which one could not give a direct clinical name, but best to classify them under a general heading indicating some internal disturbance.

DR. PISKO said he would make a diagnosis of dermatitis hemostatica in this case.

DR. WISE said he thought the case was one of "erythromelie" of Pick, now described as dermatitis atrophicans, in the early beginning, nonatrophic stage of the affection.

DR. OULMANN had suggested the name dermatitis hemostatica, which Dr. Pisko had mentioned and also thought of the erythemas which were more or less allied to angioneurotic conditions. He intended to observe the case further, to substantiate Dr. Wise's diagnosis of "erythromelie."

LICHEN PLANUS. Presented by DR. OCHS.

The patient was a man, aged 29, whose disease had been of three months' duration. He showed typical annular lesions of lichen planus of both arms and also annular lesions on the penis. There was a series of lichen papules over the chest following scratch marks, and also lichen planus of the hypertrophic variety on the legs. The interesting feature of this case was the short duration and extent of the disease. When he was first seen the lesions were more pronounced than when shown. There were no mouth lesions.

BAZIN'S DISEASE. Presented by DR. MACKEE.

The patient, E. M., was a woman, aged 23, born in Russia, and came from Dr. Fordyce's clinic. The duration of her lesions was six months. The speaker had presented her about two months previously, with a brownish red patch on the inner surface of the right leg over the calf, with a scalloped edge. In the scalloped edge of this plaque there were four punched-out ulcers, typical in appearance of an ulcerating gumma, but the Wassermann reaction was negative and the lesion did not respond to antisyphilitic treatment, so he had presented the patient as Bazin's disease. The histologic findings were those of Bazin's disease. There was certainly a remarkable resemblance to ulcerating gumma.

DISCUSSION

DR. HOWARD FOX said he never would have thought the case to be one of Bazin's disease when it was first shown. It certainly presented a clinical picture of a nodular syphilid with four or five ulcerated nodules in a semicircle.

DR. OCHS said this case simulated very much a case he presented four or five years ago, that of a young girl, 8 years old. The lesion was thought to be a sarcoid, but microscopically it proved to be a case of Bazin's disease. Dr. Wise confirmed it also microscopically. The speaker also presented another case of Bazin's disease before the Society, that of a young woman who had been previously shown and in whom the diagnosis of Bazin's disease was not at that time accepted, but was diagnosed as heredo-syphilis, but on the second presentation the diagnosis of Bazin's disease was confirmed. Here the lesions were also grouped in the same way on the legs as in the case presented by Dr. MacKee.

DR. HOWARD FOX asked Dr. MacKee's opinion regarding the comparative merits of tuberculin and roentgen ray in Bazin's disease, as he had treated the disease by both methods.

DR. MACKEE said that the twelve cases of Bazin's disease, treated with tuberculin, that he had reported, required six to ten months to get well and all recovered in that time. With the roentgen ray, with deep therapy, they would heal sometimes in one treatment, which meant one to three months instead of six to ten months.

DR. SATENSTEIN asked the exhibitor whether he was curing the pathologic process or removing the case. Dr. MacKee had said that vaccine therapy required from eight to twelve months; the speaker said that Bazin's disease would clear up in that time without any treatment.

DR. MACKEE said he had followed only three out of his twelve cases and they never relapsed. The cases treated by the roentgen ray had not been under long enough observation to tell much about the possibility of recurrence. Of course the roentgen ray did not kill the tubercle bacillus. It seemed to act mostly in preventing cellular over-activity, biologic and physiologic. Schultz had treated cases for several years and while he did not say anything about relapses, it was considered in his clinic as the best treatment for Bazin's disease, so he must have seen very few relapses.

TUBERCULOSIS VERRUCOSA CUTIS. Presented by DRS. HOWARD FOX AND OCHS.

The patient, I. T., was a married woman, aged 62, born in Norway. The disease had first appeared on the wrist, nearly two years ago, following a slight lacerated wound. It began as a "red lump" on the wrist and gradually spread to the present size, the smaller lesions appearing later. On the back of the right wrist there was a patch 2½ by 2¼ inches, elevated to one-quarter inch. It was dull red, sharply bordered and fungating. There were also two smaller areas, one on the knuckle of the first finger, a narrow infiltrated patch an inch in length and another smaller patch on the back of the first phalanx of the little finger. There were also a few scattered pustules elsewhere on the back of the hand. The patient appeared to be in good health. She was being treated by the high frequency cauterization.

TUBERCULOSIS VERRUCOSA CUTIS. Presented by DRS. HOWARD FOX AND OCHS.

The patient, Cornelius C., aged 32, was born in the United States, a driver by occupation. The eruption began seven years ago, without apparent cause, on the skin over the first metacarpo-phalangeal joint. He presented warty and crusted lesions on the back of the hand, on the first metacarpal bone and first phalanges of index and middle fingers of the right hand. He had previously been treated by salves, curettage and the roentgen ray by other physicians. He was now being treated by radium.

DISCUSSION

DR. SATENSTEIN asked what Dr. Fox was going to do for these cases, whether he was going to subject the lesions to the roentgen ray or destroy them.

DR. HOWARD FOX said he had begun to treat one of the cases with the high frequency cauterization, and the other under radium and that he would compare the two methods.

TUBERCULOSIS VERRUCOSA CUTIS. Presented by DR. BECHET.

The parents of the patient, a boy, aged 10, from the service of Dr. Kingsbury, stated that six years previously, ulcerative lesions developed on the right leg; since then he had never been free of active lesions. The family history was negative as to the presence of tuberculosis. The child had three brothers and six sisters, free from either cutaneous or visceral tuberculosis. He presented for examination, on the right leg, several large, irregular, serpiginous areas, which were markedly infiltrated and elevated, and covered here and there with a warty overgrowth; this overgrowth had been considerably diminished by carbon dioxid snow applications. Adjacent to the patches were two or three reddened, infiltrated nodules.

DISCUSSION

DR. PISKO said he would call this case scrofuloderma.

DR. MOUNT said he failed to see how some of the lesions in this case could be called scrofuloderma, as this term was used to signify an ulcerative condition of the skin secondary to an underlying tuberculosis of the lymphatic glands.

DR. SATENSTEIN said he agreed with Dr. Mount that scrofuloderma meant a breaking down of the glands with secondary involvement of the skin.

DR. WISE said he understood scrofuloderma to designate a tuberculous skin disease, the result of the breaking down of tuberculous glands, leading to direct infection of the overlying skin.

DR. BECHET said he had always considered the term scrofuloderma as a designation of the sinus formations following, or accompanying degenerating

tuberculous lymphatic glands. Such a condition did not of course exist in the case under discussion. The patient had had carbon dioxid snow applied, which partly removed the verrucous growth on the lesions.

CASE FOR DIAGNOSIS. Presented by DRS. HOWARD FOX AND OCHS.

The patient was a woman, aged 60, who presented a sharply bordered, pale reddish infiltration of the chin about 1½ inches in diameter. This had existed for the past five months. There was no evidence of scratching, no scaling and no vesiculation. The Wassermann was negative.

DISCUSSION

DR. SATENSTEIN suggested the early stage of myxedema, because the entire face, forehead and cheeks were in the same condition, namely, slightly infiltrated, just like the chin.

DR. HOWARD FOX said that patches of rosacea were as a rule rather ill defined and not sharply bordered infiltrations as in this case. The possibility of a gummous syphilid was thought of, although the Wassermann was negative.

XANTHOMA. Presented by DR. OULMANN.

The patient was a male adult who for a number of years had had diabetes and nephritic trouble. He showed a number of xanthoma lesions on the knees, elbows and soles of the feet.

ICHTHYOSIS. Presented by DR. OCHS.

The patient was a boy, aged 18, who showed a generalized ichthyosis. The patient's mother stated the lesions were only noticed after he was three months old. This was an absolutely typical case. The only remarks to be made were that it was generalized and had the typical fish scales prominently showing on both legs. No other member of his family was so afflicted. The flexor surfaces of the elbows and under the axillae were free, but otherwise his whole body was involved.

DISCUSSION

DR. MACKEE said this was one of the most magnificent cases of ichthyosis he had ever seen. One interesting feature was the complete freedom of the flexures, with one exception, the axillae.

DR. WEISS said he would like to know if there was any explanation of the popliteal regions and elbows not showing an ichthyosis.

DR. PISKO said something like this condition was seen in the prurigo of Hebra, in which the popliteal and cubital spaces were always free.

DR. SATENSTEIN said the interesting point in this case was the time of the appearance of the lesions. The mother of the patient said the condition began when he was 3 years old. He asked how would one classify this? An anomaly of function or a nevus?

KAPOSI'S SARCOMA. Presented by DR. OULMANN.

The patient was a male adult, who had been seen at the Vanderbilt Clinic and showed lesions on both legs. It looked like scleroderma, but the case was clinically as well as otherwise a case of Kaposi's sarcoma. The man developed the condition in his thirty-third year and the speaker said he had never seen an earlier case. The patient had had a number of roentgen-ray treatments.

DISCUSSION

DR. HOWARD FOX thought that in this case the clinical diagnosis agreed with the histologic. He considered it scleroderma and not Kaposi's disease. There were no nodules to be seen and, furthermore, the patient was rather young to suffer from Kaposi's sarcoma.

DR. SATENSTEIN said that in the literature there were case reports of cutaneous fibroid nodules accompanying atrophy of the skin, which atrophy had been preceded by an infiltration, very similar to that in the case presented. Instead of Kaposi's sarcoma, he considered the case one of scleroderma with fibroid nodules. Microscopically there was nothing but a sclerosis of the connective tissue in the nodules presented as sarcoma nodules. There was absolutely nothing suggestive of Kaposi's sarcoma in any of the sections examined by him.

DR. MOUNT agreed with Dr. Satenstein and could not bring himself to consider this case as one of Kaposi's disease.

DR. GOTTHEIL said he thought this a case of Kaposi's sarcoma and that the condition of the leg was common. He had had occasion to see an unusual number of these cases and in almost all of them the pseudosclerodermatous condition was presented. There were deep-seated nodules which would cause a sclerodermatous condition. He said if one of these nodules were excised they would find the cell accumulation characteristic of these cases.

DR. WISE said he had seen this case two or three months previously and at that time the patient presented lesions which were typical of sarcoma of Kaposi. When he saw the case there were deep, edematous, violaceous swellings on the backs of the hands, such as were seen only in Kaposi's sarcoma. The nodules on other parts of his body were also violaceous. He thought it a typical case of Kaposi's sarcoma and that the scleroderma of the lower extremities was a secondary manifestation, not uncommonly encountered in this affection.

DR. OULMANN said the picture had changed very much under roentgen-ray treatment, but that in some of the small lesions the sarcoma nodules could still be seen.

MALIGNANT SYPHILIS. Presented by DR. PAROUNAGIAN.

The patient, D. M., a man, aged 51, born in Russia, was a stableman by occupation. He had a generalized eruption of five months' duration. He denied having had a chancre, though a large scar on the dorsum of the penis was present. The lesions were polymorphic in character, rupial, nodular, papular, pustular, corymbiform, circinate, etc. The scalp, face, neck and the extremities were involved with a few scattered lesions on the trunk. The throat was ulcerated, with a large mucous patch on the lip. The Wassermann reaction was ++++.

DISCUSSION

DR. SATENSTEIN suggested, instead of salvarsan, that the patient at first be fed and put out into the open air. That would do him more good than salvarsan and that later the patient would probably respond better to the antisyphilitic therapy.

DR. MACKEE said he thought that this was a precocious as well as malignant case. The eruption was destructive, widespread, bilateral and to a large extent symmetrical, and represented the type seen in individuals who had heart or kidney diseases or cachexia or who were in very poor health.

DR. HOWARD FOX agreed with what his father had always taught regarding hygienic treatment of syphilis. This was a case, however, with mucous lesions on the lip that constituted a menace to society. To attempt to put this patient in good physical condition and defer active antisyphilitic treatment, would, in this case, be most improper. He thought that no time should be lost in giving the patient salvarsan.

DR. PAROUNAGIAN, in closing, said he was not in favor of the suggestion made as to the "tonic treatment" and "building up and feeding him," as the patient was swarming with spirochetes, he was a public menace, therefore, he should receive vigorous salvarsan and mercury treatment.

CARCINOMA SERPIGINOSUM. Presented by DR. OULMANN.

The patient was a male adult who had previously been presented before the Society, at which time a diagnosis of carcinoma serpiginosum was made. The lesions were on the scalp, at the back of the left ear, which was healing up, but the lesion was progressing down on the neck and new ones appeared there. The condition had been of six years' duration.

DISCUSSION

DR. SATENSTEIN said they had done a biopsy and looked for carcinoma, but did not find it. They found nothing but a chronic dermatitis.

DR. OULMANN said when he presented the patient for the first time he had rather deep ulceration and the masses were infiltrated. He had had no roentgen-ray treatment at that time. The case was healing in one place but progressing in another. The histologic picture did not show any kind of infiltration, nor any change of the epithelium of any extent and only showed a new formation of small blood vessels. There was a slight edematous condition without infiltration and there were deep scars. The speaker did not know what diagnosis to make, but it certainly was no radiodermatitis.

NEVUS ANEMICUS. Presented by DR. MACKEE.

The patient, S. P., a man, aged 19, from Dr. Fordyce's clinic, presented on the back a large, irregular, whitish patch with here and there pale, guttate macules, which were fairly well marked. There was no hyperpigmentation around the patches. On the front of the chest he had a very distinct whitish area and in the sternal region a white mottling. There was no infiltration. The skin appeared perfectly normal, excepting that it was lighter in color than the surrounding skin. In regard to the duration, the history was uncertain, but the mother had told the speaker that the white area on the right side of the sternum had been present practically since birth. He knew nothing about the duration of the other patches; the boy had only noticed them a month ago, but they may have been there some length of time. A biopsy had not helped in establishing a diagnosis and only revealed a normal epidermis with a little edema of the connective tissue. He presented it as a case of nevus anemicus.

DISCUSSION

DR. HOWARD FOX said the lesions on the back were rather suggestive of vitiligo.

DR. MACKEE, in reply to Dr. Gottheil, said that one could limit the term nevus to growths in which were found nevus cells, as, for instance, the pigmented mole. This was the usual pathologic classification. The speaker was in favor of a more liberal conception of the subject and he was inclined to place in the group of nevus any lesion that was due to a congenital anomaly of development. Regarding the possibilitiy of white lesions constituting nevi, the speaker recalled a case that he had photographed two years ago. There was a pure white, linear lesion, in the shape of a band about 3 inches wide, extending from the vertex over the neck and shoulder and down the arm to the hand. The hair in the affected area was white. The lesion was present at birth. Such a condition was a congenital anomaly of pigmentation or an anomaly of development producing a different refraction index of the skin and the speaker would regard such a lesion as a nevus.

DR. GOTTHEIL asked, as some microscopic sections had been examined, if the whiteness was due to obliteration of the blood vessels or diminution of pigment.

DR. SATENSTEIN said even in well marked cases of leukoderma there was no change in the pigmentation in the so-called white spots. The only change was at the border, where there had been increased pigmentation, but the white

spots themselves had a normal amount of pigment, and they very seldom saw a total absence of pigment. The speaker said they would see no difference, only when compared with the pigmented skin.

DR. WISE said he had read up the subject of nevus anemicus only the day previously. The blanching of the skin was not due to absence of pigment, nor to an obliteration of the blood vessels, but rather to a partial narrowing of the blood vessels—a shrinking, but no actual obliteration.

CHRONIC ECZEMA. Presented by DR. WEISS.

The patient was a male adult who had had this dermatosis seventeen years. It disappeared for four years and for the past ten years it reappeared again. The lesion started as a small, eczematous patch on the left foot, above the ankle and spread centrifugally, with thickening of the skin, due to scratching. It was itching intensely and the speaker made a diagnosis of parasitic eczema, there being present scratch marks, crusting and pachydermia. Some held it to be lichen chronicus simplex in patches. He regarded the case as chronic eczema, or as it was sometimes called in view of its rounded configuration, a parasitic eczema.

DISCUSSION

DR. OULMANN said he regarded the case as one of mycotic eczema.

DR. PAROUNAGIAN diagnosed the case lichen simplex chronicus as such cases were called by Dr. Pollitzer. Their behavior was different from the so-called chronic eczema. The lesions were usually seen on the lower extremities, consisting of one or more patches, sharply marginated, elevated, shining smooth surface, purplish in color, leathery feeling to the touch and extremely itchy, with seldom exudation present. Often they painted these patches with liquor potassae with good results, which would produce a very severe reaction in eczema.

DR. MACKEE said that he understood Vidal's lichen chronicus circumscriptus to consist of a circumscribed area of lichenification, associated with considerable itching. Dr. Weiss' case impressed him as being one of chronic eczema.

DR. WEISS said that under lichen simplex chronicus he understood a neuroderma, with papules, which in the beginning were more to be felt than seen, coupled with intense itching. Soon livid papules developed, on the summits of which a little dried blood crust showed, caused by scratching the lesions. They appeared with predilection on the chest and flexor and inner surfaces of the arms and legs. In this case there was a large patch of seventeen years' duration, with crusting, itching and thickening, and although called by a misnomer, he thought it a parasitic eczema, the parasite of which had not yet been found.

Correspondence

CASE FOR DIAGNOSIS

To the Editor:—In the hope that some of the readers of THE JOURNAL might be able to enlighten me about a case under my observation, I submit the history of the patient, as follows:

E. S. M., a man, aged 35, a bottler by occupation, is employed in a Coca-Cola manufacturing plant. He came under my observation on Sept. 9, 1917. He had had no illnesses since childhood; the Wassermann reaction was negative. He complained of spasms of violent, uncontrollable itching and burning of the face, chiefly on the left side; the seizures came on every few minutes, day and night, for the past three days. Antedating the disorder, he had been out for a motor ride, felt chilly, and had fainted. Four days later, the itching set in. When the attacks came on, the patient would grasp a towel, the bedclothes, or with his bare hands would briskly rub—not scratch—the face for a few minutes, when the storm would pass. Any manipulation of the affected parts would induce an attack. He was afraid to speak or swallow as the consequent muscular movements would precipitate a seizure.

The face was erythematous, with small areas of abraded skin. The temperature was 100 F., and the pulse, 80. Examination of the mouth revealed one decayed tooth, which was apparently causing no trouble. No wisdom teeth were in evidence and since they had never been extracted, it was deemed wise to make a roentgenogram, which revealed a congenital absence of these structures. The patient's condition was pitiful from mental unrest and loss of sleep. Sedatives gave a measure of relief. Free salivation supervened; at times the saliva would run from the mouth. Twitching of the facial muscles and of the sterno-mastoid muscles were noticed. Transient delirium set in.

An eruption, herpetic in character, appeared along the course of the intercostal nerves of the left side and on the anterior aspect of the right leg below the knee, following the nerve distribution. Itching was manifest in these areas, but was not so violent in character. There was no pain. Examination of the nose revealed no reflex cause of the malady.

At the expiration of three weeks he was discharged from the hospital, apparently well on the road to recovery, and four days later he went back to work.

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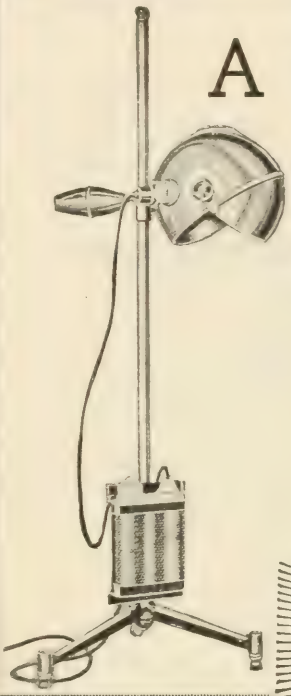

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